# SUICIDE:

# THEOLOGICAL ETHICS AND PASTORAL COUNSELING

by

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# CHAPTER I

# INTRODUCTION

## I. THE PURPOSE OF THE STUDY

### The Problem of Suicide

Suicide has been a perennial problem for mankind since antiquity. Probably one of the earliest record of the issue was an Egyptian papyrus called "A Dispute over Suicide" composed in the First Intermediate Period (c. 2280-2000 B. C.).[1] It was written by an unknown author and contained one hundred and fifty-five vertical lines. The poem echoes a note of despair:

> My soul opened its mouth to me that it might answer what I had said. If thou recallest burial, it is a sad mother. It is the bringing of tears, making a man sad. It is dragging a man from his house and casting him on the hillside. Thou shalt never go up that thou mayest see the sun. Those who built in granite and who hewed chawlers in five pyramid(s) with good work, when the builders became gods their offering stelae were destroyed like (those of) the weary ones that died on the dyke, through lack of a survivor, the water having taken its toll, and the sun likewise to whom the fishes of the river banks talk. Listen to me. Behold it is good for men to listen. Follow pleasure and forget care....
>
> I opened my mouth to my soul that I might answer what I had said.
>
> Behold my name stinks
>   Behold more than the stench of fish
>   On a summer's day when the sky is hot....
> Behold my name stinks
>   Behold more than a woman,

---

[1] T. W. Thacker, "A Dispute over Suicide," M. D. Winton Thomas, ed., Documents from Old Testament Times, (New York: Harper and Brothers, 1958), p. 1962.

About whom a lie has been told to a man,
Behold my name stinks
Behold more than a sturdy lad
About whom it is said 'He belongs to his rival'.

To whom shall I speak today?
Brothers are evil,
The companions of yesterday do not love.
To whom shall I speak today?
Hearts are rapacious,
Every man seizes the goods of his neighbor...
To whom shall I speak today?
Men are contented with evil,
Goodness is neglected everywhere.
To whom shall I speak today?
One who should make a man enraged by his evil behavior
Makes everyone laugh, though his iniquity is grievous....
To whom shall I speak today?
The wrongdoer is an intimate,
The brother with whom one should act is become an enemy.
To whom shall I speak today?
Yesterday is not remembered,
No one now helps him that hath done (good).
To whom shall I speak today?
Faces are averted,
Every man has (his) face downcast towards his brethren.
To whom shall I speak today?
Hearts are rapacious,
No man has a heart upon which one can rely.
To whom shall I speak today?
There are no righteous men.
The land is left over to workers of inquity...
To whom shall I speak today?
I am laden with misery
Through lack of an intimate.
To whom shall I speak today?
The sin that roams the land,
It has no end.
Death is in my sight today
(Like) the recovery of a sick man,
Like going abroad after detention.
Death is in my sight today
Like the smell of myrrh,
Like sitting under an awning on a windy day.
Death is in my sight today.
Like the scent of lotus flowers,
Like sitting on the bank of drunkenness.
Death is in my sight today
Like a well trodden way,

  As when a man returns home from an expedition.
Death is in my sight today
  Like the clearing of the sky,
  Like a man attracted thereby to what he knows not.
Death is in my sight today
  Like the longing of a man to see home,
  When he has spent many years held in captivity.
Surely he who is yonder shall
  Be a living god,
  Punishing the sin of him who commits it.
Surely he who is yonder shall
  Stand in the barque of the sun,
  Causing the choicest things to be given therefrom to
  the temples.
Surely he who is yonder shall
  Be a man of knowledge,
  Who cannot be prevented from petitioning
  Re when he speaks.

> What my soul said to me. Put care aside, my comrade and brother. Make an offering on the brazier and cling to life, according as I (?) have said. Desire me here and reject the West, but desire to reach the West when thy body goes into the earth, that I may alight after thou hast grown weary. Then let us make an abode together.
> IT IS FINISHED FROM ITS BEGINNING TO ITS END, AS IT WAS FOUND IN WRITING.[2]

Ambivalence between life and death is the central theme of the discourse, "A Dispute over Suicide". There is a vigorous exchange between the soul and the self over this issue. The soul argues that the reality of death is separation and grief and is no respecter of social position. But the self has another understanding of death. The starting point is the loss of personal worth. He bemoans his fate: the dishonor of his name, the injustice and depravity of society, the reversal of value and honor, the absence of the good, the severance of friendship. Gradually his pessimism is embodied in a general mistrust of the world. Rather than an affirmation of life the self moves toward a fantasy of death. For the suicidal self, death is a cure, a vacation, a fragrance, a shelter, a drunken joy, a familiar path, a clarity, an indescribable allurement, and a home sickness. In death he expects to achieve the triumph of immortality and to be a god who will punish the unjust, grant favors to worshippers, and have a special relationship with God (Re).

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[2] Ibid., pp. 164-166.

But the advice of the soul is to cling to life and to fulfill one's responsibility to religion. The soul affirms a normal life and a gradual approach of death in old age.

Like this man of antiquity who disputed with his soul over suicide, modern man is also confronted with this problem. There are at least twenty thousand recorded suicidal deaths in the United States every year. Suicide is now one of the first ten causes of all deaths and one of the first five causes of death among the younger age groups in this country.[3] The average rate of suicide is approximately ten per one hundred-thousand persons.[4] It has been estimated that approximately three million persons in the United States have made suicidal attempts at some previous time in their lives; and a minority of about fifteen per cent of these persons will later repeat the suicidal action.[5]

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[3] Robert E. Litman, and others, "Suicide Prevention Telephone Service," Journal of the American Medical Association, CXCII (April 5, 1965), p.21.

[4] Robert E. Litman, "Psychiatric Hospitals and Suicide Prevention Centers," Comprehensive Psychiatry, VI 2 (April, 1965), p. 119.

[5] Robert E. Litman, "Police Aspects of Suicide," Police (January-February, 1966), p. 3.

There are as many as eight persons who attempt and survive for every one who commits suicide.[6] In 1963 medical examiners and coroners certified in California approximately two thousand eight-hundred deaths as suicide. About ten percent of these suicides were over sixty-five years old, but the majority were young and middle-aged persons.[7] Moreover, there are annually approximately one thousand deaths certified as suicide in the city of Los Angeles.[8] It has been estimated that there may also be from twenty-thousand to thirty-thousand suicidal-threat situations in Los Angeles every year as well.[9]

The references to the soul, to good and evil, and to immortality and God in "A Dispute over Suicide" point to the place of religion in the ancient and modern dilemma of suicide. Paul W. Pretzel, pastoral counselor at the Los Angeles Suicide Prevention Center, has observed:

> Historically, religion has seen the problem of suicide as part of its province of concern because religion deals with the spiritual development of persons and when a person is suicidal, he is expressing a spiritual crisis of the gravest proportion. Feelings of guilt, shame, abandonment, anger and hopelessness are commonly encountered in suicidal persons, and these are feelings that religion has traditionally felt called to respond to.[10]

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[6] Norman L. Farberow, Edwin S. Shneidman, Robert E. Litman, "The Suicidal Patient and the Physician," Mind, I:69 (March, 1963), p. 2.

[7] Robert E. Litman, "Acutely Suicidal Patients Management in General Medical Practice," California Medicine, CIV:3 (March, 1966), pp. 168, 169.

[8] Robert E. Litman, and others, "Investigations of Equivocal Suicides," Journal of the American Medical Association, CLXXXIV (June 22, 1963), p. 924.

[9] Robert E. Litman, "Psychiatric Hospitals...," p. 120.

[10] Paul W. Pretzel, "The Clergy and Suicide Prevention" (an unpublished mimeographed paper, June, 1966), p. 1.

Recent research concerning the religious beliefs of suicidal persons indicate that such people, regardless of their religious background, could not trust the universe, God, nor helping persons.[11] Likewise, the man in "A Dispute over Suicide" expressed concrete mistrust when he stated, "Hearts are rapacious. No man has a heart upon which one can rely."[12] However, the positive role of religion is the affirmation of life for the suicidal person. It desires to foster trust in self, others, and God as well as to support good action.

## The Role of the Modern Minister

The national study conducted for the Joint Commission on Mental Illness and Health (Gurin, Voroff, and Feld 1960) revealed that forty-two percent of the two thousand sixty persons interviewed sought the clergy in cases of mental distress.[13] One may conclude that ministers play a vital role in the care of emotionally disturbed persons. Moreover, clergymen have taken an active part in suicide prevention.[14]

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[11] Ibid., pp. 12, 13.

[12] Thacker, Op. cit., p. 165.

[13] Richard V. McCann, The Churches and Mental Health (New York: Basic Books, 1962), p. 69.

[14] Among the clergymen prominent in suicide prevention are: Rev. H. Leslie Christie, Help Line Telephone Clinic, Los Angeles. Rev. Philip T. Comfort, Holy Cross Methodist Church, Stockton, Calif. Rev. Donald R. Fauble, Rev. Ford White, Rev. Howard Durham, Suicide Prevention Service of Greater Chattanooga, Tenn. Rev. Robert Gunther, Memorial Hospital of Long Beach, Calif. Rev. Kenneth Hildebrand, Central Church, Chicago. Rev. Virgil A. Kraft, The Peoples Church, Chicago. Rev. Bernard Mayes, Suicide Prevention of San Francisco. Rev. Kenneth B. Murphy, RESCUE, Inc., Boston. Rev. Paul Pretzel, Los Angeles Suicide Prevention Center. Rev. Chad Varah, The Samaritans, St. Stephen Walbrook Church, London, England. Rev. James Wade, Suicide Prevention Service, Inc., Portland, Oregon. Rev. Alan Walker, Help-Line Foundation, Sydney, Australia. Rev. Harry M. Warren, National Save-a-Life League, New York.

Religious literature has focused on the topic of suicide. Several theologians of the Christian Church (Augustine, Aquinas, Bonhoeffer, Barth) have considered the subject of suicide in the ethical sections of theological treatises.[15] Considerable attention has also been given to suicide and pastoral counseling. However, recent articles have almost exclusively concentrated on the psychological application of suicide prevention for the minister.[16]

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[15] See especially:

Augustine, The City of God (New York: Modern Library, 1950), I:22-23.

Thomas Aquinas, Summa Theologica (New York: Benziger Brothers 1947), II, 1469.

Dietrich Bonhoeffer, Ethics (New York: Macmillan, 1955), pp. 166-172.

[16] See especially:

John Sutherland Bonnell, "The Ultimate in Escape," Pastoral Psychology, IX:81 (February, 1958).

Wayne E. Oates, "The Funeral of a Suicide"; Samuel Southard, "The Minister's Role in Attempted Suicide"; Seward Hiltner, "Suicidal Reflections"; Herbert M. Herdin, "What the Pastor Ought to Know About Suicide"; Earl A. Loomis, Jr., "The Consultation Clinic" The Pastor and Suicide: Pastoral Psychology, IV:39 (December, 1953).

Earl A. Grollman, "Pastoral Counseling of the Potential Suicidal Person," Pastoral Psychology, XVI:160 (January, 1966).

Howard J. Clinebell, Jr., "First Aid in Counseling VII, The Suicidal Emergency," Expository Times, LXXVII:11 (August, 1966).

Edwin S. Shneidman, "The Clergy's Responsibility in Suicide Behavior" (an unpublished mimeographed paper).

Norman Tabachnik, "Suicide and the Clergy," Bulletin The Council for Social Service, CXCIV (June, 1966).

Paul W. Pretzel, "The Clergy and Suicide Prevention."

No significant research has been undertaken to correlate theological ethics and pastoral counseling concerning the problem of suicide. At least two questions are pertinent in the correlation: (1) is suicide a good or bad act? and (2) what is the proper therapy for a suicidal person? Ethical rationale as well as operational procedure are at stake at this point. Seward Hiltner explained the relationships between various disciplines of theology when he said:

> Within the whole body of divinity what is distinctive about the operation-centered inquiries such as pastoral theology is that their theological conclusions, or theory, or basic principles, emerge from reflection primarily on acts or events or functions from a particular perspective. There are other branches of theology, such as biblical theology or doctrinal theology, whose organizing principle is of a different nature. The study of the Bible, or biblical theology, is centered logically around anything that contributes to understanding the meaning, development, and significance of that book and the poeple and events and experiences lying behind the book. The study of doctrine is organized systematically and logically around the relation of doctrines to one another and their mutually reinforcing capacity to give testimony to the total faith. From these focal concerns each of the logic-centered fields of theology pursues its special investigations, which of course include the questions of practical significance and implication.[17]

The modern minister must undertake the correlation of these two areas of investigation, the logic-centered field of theological ethics and the operation-centered field of pastoral counseling (a division of pastoral theology) when he confronts the problem of suicide.

## Definitions

Brief consideration must be given to the definitions of the key terms: "suicide", "theological ethics", and "pastoral counseling."

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[17] Seward Hiltner, Preface to Pastoral Theology, (New York: Abingdon Press, 1958), pp. 20, 21.

For purposes of clarification at this point, we will adopt the definition of "suicide" set forth by Edwin S. Shneidman. He stated:

> As a beginning, a straightforward definition of suicide might read "Suicide is the human act of self-intentioned cessation." At least five points are to be noted in this brief definition: (a) it states that suicide is a human act; (b) it combines both the decedent's conscious wish to be dead and his actions to carry out that wish; (c) it implies that the motivations of the deceased may have to be inferred and his behaviors interpreted by others, using such evidence as a suicide note, spoken testimony, or retrospective reconstruction of victim's intention; (d) it states that the goal of the action relates to death, rather than to self-injury, self-mutilation, inimical or self-reducing behaviors; and (e) it focuses on the concept of cessation--the final stopping or naughtment of the individual's conscious introspective life.[18]

Thus, suicide is a human act which carries out the conscious death wish of the decedent through actions; which may infer evidence of self-destructive behavior and/or intention interpreted by others; whose goal relates to death; and which focuses on cessation.

Concerning the term "theological ethics" there are various systems which are current in Protestant ethical thought.[19] Apart from methodological differences,[20] one may state that Christian ethics in the broadest sense is "...the effort of the Christian community to criticize its moral action by means of reflection."[21] It is the task of the Christian community to reflect on the nature of moral life and action in self-criticism through universal principles. It is the examination of the morality of ethical decision.

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[18] Edwin S. Shneidman, "Suicidal Phenomena: Their Definition and Classification" (an unpublished mimeographed paper), p. 1.

[19] James M. Gustafson, "Christian Ethics," in Religion (Englewood Cliffs, N. J.: Prentice-Hall, Inc.,1965), pp. 287-335.

[20] For a concise treatment of the methodological problem in Protestant theological ethics, see Joseph Hough, "Contemporary Philosophy Mulled," Claremont Collegian, II:18 (November 30, 1966), pp. 2, 4.

[21] James M. Gustafson, "Introduction," in H. Richard Niebuhr, The Responsible Self (New York: Harper and Row, 1963), p. 8.

Regarding the term "pastoral counseling," a definition orientated to our study is:

> Pastoral counseling is the utilization, by a minister, of one-to-one or small group relationship to help people handle their problems of living more adequately and grow toward fulfilling their potentialities. This is achieved by helping them reduce the inner blocks which prevent them from relating in need-satisfying ways.[22]

Such an explanation supersedes other definitions of pastoral counseling[23] and points toward an action-oriented approach to suicide therapy.

## Hypothesis of the Study

Both areas of theological ethics and pastoral counseling are in transition states. What are the implications for the issue of suicide? Concerning Protestant theological ethics, James M. Gustafson summarized the present debate between contextualism and the ethics of principles. He said:

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[22] Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (New York: Abingdon Press, 1966), p. 20.

[23] See especially:

Seward Hiltner Pastoral Counseling (New York: Abingdon Press, 1949), p. 19.

Carroll A. Wise Pastoral Counseling (New York: Harper and Brothers, 1951), p. 4.

Paul E. Johnson Psychology of Pastoral Care (New York, Nashville: Abingdon Cokesbury, 1953), p. 24.

> Those who apply the term contextualism pejoratively see little place for the use of traditional ethical principles and moral reasoning in this mode of work. They see in it an excessively existentialist posture that relies too heavily upon imagination, intuition, and free response. Paul Ramsay and John C. Bennett have been, in different ways, the defenders of "principles." They have stressed the importance of statements of moral imperatives: in Bennett's case, goals derived from the biblical norm of love; in Ramsay's case, principles of right conduct shaped by Christian love and natural law. The critics of ethics of principles believe that this view errs in not taking the activity of the living God as the theological starting point for ethics; that it excessively intellectualizes the moral life by reducing it to the logical applications of ethical generalizations; and that consequently it has a hard time closing the gap between principle and actions.[24]

These methodological approaches toward morality ultimately affect the ethics of suicide. Furthermore, basic changes have occurred in the field of pastoral counseling. Howard J. Clinebell, Jr. recently wrote:

> Actually pastoral counseling practice has already begun to turn the necessary corner. Older methods are being challenged, their effectiveness questioned by many practitioners of this pastoral art. Basic modifications have taken place in the way many of us practice pastoral counseling. It is important that our conceptual understanding keep abreast of these changes. Otherwise, a foundation of understanding for future changes will be lacking.[25]

Specifically, Clinebell emphasized the shift from insight-oriented to action-oriented pastoral counseling. In his explanation of the revision he observed:

> The pastor who uses the revised model is more apt to confront the person (within a strong counseling relationship) with the need to face his unconstructive patterns of living. Living in self-contradictory ways which violate one's sense of justice, integrity, and respect for persons is seen as a cause and not just a symptom of inner conflicts. Many people are capable of making constructive changes in this behavior whether or not their inner conflicts are

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[24] Gustafson, "Christian Ethics," p. 326.

[25] Clinebell, Basic Types..., p. 17.

> resolved. Therefore, the person's guiding values and the behavior resulting therefrom should be examined, not just in terms of how he feels about these matters (although this is important), but also in terms of how they influence his relationships and sense of worth and what he can do to live more constructively.[26]

Applications of these pastoral counseling principles should be made to the care of suicidal persons.

In short, the hypothesis of this study is that a new understanding of theological ethics and pastoral counseling is required in the church's approach to suicide and suicidal persons.

## II. THE METHODOLOGY FOR THE STUDY

### Introduction

The essential methodology of the study will be formulated around three headings: the old model, contemporary changes, and the revised model.[27] The study will begin with the Old Model of the historical Church, i.e. theological positions, the institutional strictures, and the pastoral practices regarding the problem of suicide. It will move to a consideration of contemporary changes in Protestant theological ethics applied to the subject of suicide as well as in pastoral counseling with suicidal persons. Theoretical discussion will be supplemented by statistical information obtained from clergy about suicide-counseling and theology. Finally, the study will suggest a Revised Model based on views in Protestant theological ethics and Protestant pastoral counseling.

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[26] Ibid., p. 33.

[27] I am indebted to Howard J. Clinebell, Jr. Ibid., pp. 27-40, for the use of his terms "old model" and "revised model."

## Statistical Questionnaire

A research project was designed to investigate the attitudes and practices of clergymen regarding suicide. A four-page prospectus of the purpose, limitations, methodology, and possible findings was approved by Dr. Edwin S. Shneidman and Dr. Norman L. Farberow, co-directors of the Los Angeles Suicide Prevention Center. A grant was awarded by the Los Angeles Suicide Prevention Center for the investigation.

A statistical questionnaire was devised to correlate the pastoral counseling experiences and theological attitudes of ministers regarding suicide. Dr. Warren Breed, associate professor of sociology at Tulane University and a 1965-1966 Fellow at the Center for the Scientific Study of Suicide, rendered technical assistance in the design of the instrument. The questionnaire was distributed to a group of seminary students and ministers for preliminary testing. Questionnaire items with answers were studies as sample responses. Revisions of inevitable defects were made by the researcher and Dr. Breed. Subsequently the questionnaire was sent to Protestant ministers whose parishes were members of Councils of Churches in Los Angeles County. The selection of these ministers excluded other diverse elements of Protestantism (i.e. ultra-liberal Unitarian-Universalist or fundamental Pentecost and Southern Baptist clergy). The eleven affiliated councils of churches in Los Angeles County were: Los Angeles Council of Churches, Long Beach Council of Churches, Pasadena Area

Council of Churches, Glendale Council of Churches, Santa Monica Bay Area Council of Churches, Whittier Area Council of Churches, Claremont Council of Churches, Antelope Valley Council of Churches, San Pedro Council of Churches, and Palos Verdes Peninsula Council of Churches.

The self-administered three-page questionnaire with an introductory letter of explanation and a self-addressed returned envelope was mailed through Los Angeles Suicide Prevention Center to council member churches in Los Angeles County. Two hundred and fifteen ministers (forty percent) answered after five weeks. A second mailing was sent to the clergy who did not respond in the initial return in order to guard against a 'biased sample' of those who were interested in the study and who replied. Seven weeks later there were one hundred and eight more responses. The final number of returned questionnaires was three hundred and twenty-three (sixty percent).

A coding guide was devised to transfer the data from the questionnaire to statistical coding forms. There were forty-four items to be scored on each questionnaire. An IBM card was punched corresponding to the numbers on each sheet. Using a card-sorter at the University of Southern California, the researcher tabulated the statistics. Cross-correlations were made between age and theological view, between clinical training and theological view, between pastoral care experience and theological view, between referral and clinical training, between denomination and theological view, between education and theological view, between education and referral, and between clinical training and certainty in counseling. Statistical empirical results from the questionnaire were used in the discussion of Protestant theological ethics and pastoral counseling.[28] (See Appendix for introductory letters, questionnaire, and statistical coding form.)

## Case Studies

The case studies focused on intra-psychic dynamics of personal theological views and pastoral counseling experiences of clergymen with suicides. Methodological research via the depth-interview approach outlined by Edwin S. Shneidman served as a guide-line for the case studies. Shneidman suggested:

> We should now move forward to dynamic autospection - dealing with the exciting and complicated real world of feelings, thoughts, aspirations, urges, impulses, and behaviors as they relate themselves within the individual.[29]
>
> Rather, what I am saying is that we should not be content to know some few pre-selected facts about many people, or even many facts about only one person, but rather should aspire to investigate intensively several people -- paranormal, normal, super-normal -- seeking what is common to all, present in many, and existent only in each-the universal, the ubiquitous, and the unique -- all the while keeping our minds open for new groupings, new relationships of intra-human aspects, new human complexes. And within each of these three we need to distinguish between what is pervasive, habitual, characterologic about a person on the one hand and what are the current, transient, waxing, exacerbated, "clinical" aspects of that same individual, on the other hand.[30]

The case studies enlarged the statistical findings of the clergy through an investigation of five ministers, seeking the universal, the ubiquitous, and the unique as well as looking for new groupings, new relationships, and new human complexes. The selection of clergymen for these interviews was made from the questionnaire returns according to the following criteria:

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[28] See Appendix for Questionnaire for Clergy Information on Suicide Counseling and Theology, accompanying letters of introduction and explanation, Coding Guide for Clergy Information on Suicide Counseling and Theology, numbering sheet.

[29] Edwin S. Shneidman, "Some Reflections on Personality Explorers, 1938 - 1963"; Journal of Projective Techniques and Personality Assessment, XXVIII, 2 (1964), p. 159.

[30] Ibid., pp. 158, 159.

1. He must be a participant in the statistical questionnaire study.
2. He must be a parish minister of a congregation in the Los Angeles County affiliated with a Protestant Council of Churches.
3. He must have recent counseling experiences with at least three suicidal persons.
4. He must have pastoral care experience with funerals of suicidal persons.
5. He must be willing to devote an adequate number of sessions to be interviewed.

Five Protestant clergymen (a Presbyterian, a Methodist, a United Church of Christ-Congregationalist, a Baptist, and an Episcopalian) were chosen according to the criteria mentioned. No attempt was made to get a representative sample of clergymen according to age, denomination, clinical training, theological position, effectiveness in counseling, etc. The case findings described the pastoral counseling experiences and theological views of these five individual clergymen regarding suicide.

The interviews covered five major areas relating to the personal, theological and pastoral counseling views of the clergyman: introduction, training in pastoral counseling, first contact with a suicidal person, case studies, and suicidal and personal theology on suicide. The introduction contained information about various experiences in the parish ministry, personal religious creed, and academic education. Training in pastoral counseling was explored to understand the pastoral care background of the minister. The researcher was interested in the first contact with a suicidal person by the clergyman which might have significantly influenced his later counseling. Case studies dealt with age and sex, problem situation, establishment of a relationship, onset of self-destructive behavior, family situation, interpersonal relationships, course of counseling, religious resources, referral therapy, and pastoral funeral care. Suicide and personal theology covered religious evaluation of the suicidal act, personal theology for suicidal persons, improvements in church suicide prevention, and resources of the church.

Although the interviews were not conducted in a rigid question and answer manner, the minister was encouraged to express his private reactions to suicidal persons in his counseling experiences and his theological views concerning suicide. The subject was interviewed in his church office. Interviews with a minister ranged from a total of four to seven hours and were taped in full. The cases were written from transcriptions of the tapes. Ambiguities in certain areas were clarified by further questions from the interviewer. There was an attempt to preserve the essential thoughts of each subject in the composition of the case study.

# CHAPTER II

# THE OLD MODEL

## I. THEOLOGICAL POSITION

The purpose of this chapter is to explain the theological arguments of Augustine and Aquinas on suicide; subsequent pronouncements and later modifications by church councils and canon law, with particular attention to burial restrictions of suicides; and pastoral practice which indirectly influenced desecration of suicide corpses. This image shaped by the Church is termed The Old Model.

### Augustine

The City of God (413 A.D.) is a theological apology which answered those who blamed the Christians for the fall and destruction of Rome in 410 A.D. Although the Roman empire was already in a state of deterioration, the pagans of Rome used Christianity as a scapegoat for the catastrophe. The subject of suicide emerges early in the middle of Book One. Augustine refers to the suicide of some unmarried women who were consecrated to the church and were sexually molested during the capture of Rome.[1]

His basic position is that the seat of virtue is the sanctity of the soul and remains even when the body is violated without consent.[2]

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[1] Augustine, The City of God (New York: Modern Library, 1950), I:21.

[2] *Ibid.*, pp. 22, 23.

Apparently some of these consecrated virgins committed suicide rather than bear the disgrace of unchastity. In this particular instance, Augustine leans toward forgiveness. However, he contends that homicide and suicide are examples of unlawful acts. The sin of suicide can only compound a given tragic situation. The question is: who should be blamed for the act? Augustine argues that it is not the fault of the unconsenting woman but that it is the sin of the one who violated her.[3] Therefore, Christian women who have been sexually violated without consent should not take upon themselves the guilt of others. Their consolation is the witness of their own conscience in the situation. They can enjoy the glory of chastity within their own soul.[4]

Turning from this incident, Augustine observes that there is no scriptural reference for the divine sanction of suicide when the motive is to escape from this life for the enjoyment of immortality.[5] The general law, "Thou shalt not kill," prohibits suicide. The commandment refers exclusively to man. Plants and animals are dissociated from man because plants lack sensation and animals are irrational. The Creator has rather subjected animals and plants to man for his use. Augustine further appeals to the law, "Thou shalt love thy neighbor as thyself." Suicide is a violation of self-love to the extent that the love of our neighbor is regulated by the love of ourselves.[6]

However, divine authority is granted in certain instances of suicide. A person (i.e. a soldier, an enforcer of law) who represents a government in the interest of public justice does not violate the commandment, "Thou shalt not kill," because his actions are sanctioned by delegated authority. The other exception is made when persons such as Abraham, Jephthah, and Samson were ready to take life in obedience to the special command of God.[7] But suicide is generally an expression of a weak mind when it is committed to escape hardship or the sins of others. Sound judgment does not advise suicide in order to escape the punishment of an enemy or the calamity of this life. Rather Augustine exhorts Christians to suffer for a period the consequence of conquest which may be divine testing and correction. Christians subjected to such humiliating conditions will not be deserted by God.[8]

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[3] Ibid., p. 22.

[4] Ibid., p. 22, 23.

[5] Ibid., p. 26.

[6] Ibid.

In the end, Augustine asserts that the Christian is to maintain a good conscience even when sinful outrage is committed against him. Suicide is "a detestable and damable wickedness."[9] The Christian is not to resort to it. The grace of God upholds him even though there is a loss of chastity.[10]

### Aquinas

In Saint Thomas Aquinas' Summa Theologica, the problem of suicide is given its first systematic treatment. The specific pronouncements on suicide are in the fifth article, "Whether It is Lawful to Kill Oneself?" under question 64, Of Murder, in Part 11-11 of Summa

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[7] Ibid., p. 27.

[8] Ibid., pp. 28, 30.

[9] Ibid., p. 30.

[10] Ibid.

Theologica Volume Two. Aquinas begins his discussion of suicide with Augustine's argument against self-murder. The statement, "Thou shalt not kill," refers to the killing of oneself as well as other men. However, he develops three reasons for the unlawful nature of suicide:

> First, because everything naturally loves itself, the result being that everything naturally keeps itself in being, and resists corruptions so far as it can. Wherefore suicide is contrary to the inclination of nature, and to charity whereby every man should love himself.[11]
>
> Secondly, because every part, as such, belongs to the whole. Now every man is part of the community, and so, as such, he belongs to the community.[12]
>
> Thirdly, because life is God's gift to man, and is subject to His power, Who kills and makes to live. Hence, whoever takes his own life, sins against God, even as he who kills another's slave, sins against that slave's master, and as he who usurps to himself judgment of a matter not entrusted to him.[13]

Aquinas argues against suicide on the basis of natural law, social obligation, and subjugation to God. Suicide violates the inclination of natural process; is opposite to self-love which naturally keeps itself from corruption; and is therefore a mortal sin. He then moves from natural law governing man to involvement in society. As a member of the community man injures the whole society when he commits suicide. Finally, man sins against God in the act of suicide. Life is God's gift to man. God alone has the power to pronounce sentence over life and death. Therefore, man usurps the authority of God when he takes his own life.

Given Aquinas' theological position against suicide, possible objections are raised for the justification of the suicidal act. The objections are closely correlated and countered with responses which reinforce Aquinas' viewpoint. The first objection proposes that it seems lawful for a man to kill himself. Granted that murder is a sin contrary to justice, no man can do an injustice to himself. Therefore, no man can sin by suicide. Aquinas follows the argument that murder is a sin contrary to justice and furthermore is against the love which a man should have toward himself. However, he asserts that suicide is a sin in relationship to oneself, to the community, and to God and is likewise opposed to justice. Therefore, suicide and murder violate the divine command, "Thou shalt not kill." The second objection reasons that it is lawful for one who exercises public authority to kill evildoers. He who exercises public authority is sometimes an evildoer. Therefore, a man may lawfully kill himself. In response to this fallacious logic, Aquinas rules that no man can judge himself in an act of suicide. A man may exercise public authority to put to death an evildoer, but he may not exercise such authority over himself. The judgment belongs to society. His only course of action is to commit himself to the verdict of others.[14]

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[11] Thomas Aquinas, Summa Theologica (New York: Benziger Brothers, 1947), II, 1469.

[12] Ibid.

[13] Ibid.

The third objection claims that suicide avoids the evil of an unhappy life or the shame of sin. Furthermore, suicide is the lesser evil in comparison to other sins if the intention of suicide is to escape present afflictions, a committed sin, danger of sexual violation, or temptation. But according to Aquinas, suicidal death is the ultimate and most fearsome evil of this life. Repentance of sins is provided for man. However, the sin of suicide exterminates temporal existence and excludes the possibility of repentance in this life.[15]

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[14] Ibid.

The fourth objection appeals to Samson who killed himself and who was considered a man of God in Hebrews 11:32. The argument implies that scripture excused his suicidal death. Therefore, suicide is lawful. For Aquinas the death of Samson is an example of self-sacrifice in obedience to the command of God. It is therefore an exceptional case. The final objection relates that a man named Razias died nobly in suicide rather than suffer abuses at the hands of wicked men (2 Machabees 14:42). The intention of noble death is a sanction for suicide. From Aquinas' perspective true fortitude assumes the possibility that a man may be slained for the virtue of the good. Thus, suicide avoids fortitude and is not an act of nobility. The suicidal person is a weak soul who is unable to bear the implications of fortitude.[16]

## II. INSTITUTIONAL STRICTURES

### Church Council Pronouncements

In 452 A.D. the Council of Arles was the first official religious body to discuss suicide. It declared that suicide was an act inspired by diabolical possession.[17] Fedden pointed out that the council wanted to single out suicide within the slave class in order to preserve the feudal system. He said:

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[15] Ibid.

[16] Ibid., pp. 1469, 1470.

[17] Louis I. Dublin, Suicide (New York: Ronald Press, 1963), p. 139.

> The Christian bishops at Arles, in fact, did little but reaffirm the stigma which long before had been attached to suicide in the statutes of the Imperial College at Lanuvium, an institution largely devoted to the education of slaves. The Council really broke no new ground and it gave no expression to the growing psychological horror of suicide as such. Not the act, but dislike of its repercussions as they affect the master and landowner, provides the motive which makes the act criminal in certain cases and envisages the suicide as diabolico repletus furore.[18]

Almost a century later the II Council of Orleans (533 A.D.) ordered that offerings (oblationes) be refused for suicides.[19] The Council of Braga (563 A.D.) denied religious rites at the burial of suicides. Moreover, since such persons died in mortal sin, the bodies of suicides were not to be treated with respect.[20] The Council of Auxerre fifteen years later reaffirmed the penalties and the principle of indiscreminate condemnation. The Antisidor Council (590 A.D.) added that suicides could not expiate any degree of sinfulness through offerings.[21] Attempted suicides were punished by the Council of Toledo (693 A.D.) with exclusion from Church fellowship for two months.[22] Furthermore, denial of Christian burial rites was even extended to those who died in tournaments, jousts or similar forbidden contests, and the III Council of Valence (855 A.D.) considered them as suicidal deaths. However, if death occurred after the battle, they could receive the last sacrament but not Christian burial.[23]

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[18] Henry Romilly Fedden, Suicide (London: Peter Davies, 1938), p. 108.

[19] Charles A. Kerin, The Privation of Christian Burial (Washington Catholic University of America Press, 1941), p. 15. He wrote concerning oblationes:

"Further, the oblationes were refused in the case of suicides. Originally the oblationes were gift-offerings brought to the altar by the faithful and offered to the priest. They consisted of bread and wine for the Sacrifice. The surplus that was left after the Mass was distributed to the poor. This practice developed into the custom of making offerings to the Church on various occasions, especially that of a death, in order that the satisfaction of the offering might be enjoyed by the soul of the deceased. In time, also, this offering took the form of money and was used for the support of the Church as well as of the poor. For the Church to refuse to accept the offerings made for a particular deceased person, or for her to forbid the offerings to be made, clearly implied that such a one was not of the fold or that he had been excommunicated. Hence their refusal meant the refusal of Christian burial."

[20] Dublin, Op. cit.

There was a brief period when the Church relaxed its attitude on suicide. In 829 A.D. the definitive text of the Penitentials provided that masses and prayers could be said for insane suicides. The Council of Troyes further officially modified the strictness of previous legislation by admitting certain funeral rites to suicides.[24] Although the Council of Nines (1284 A.D.) confirmed all previous legislation on suicide,[25] Kerin wrote concerning the period from 1179 to 1614:

> Moreover, it was already then the opinion that for anyone found dead, even in circumstances that could indicate either suicide or accident, the presumption of death by accident was in favor of the deceased until death by suicide was established. Further, if one attempted suicide but did not succeed, and upon revival confessed

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[22] Norman St. John-Stevas, Life, Death and the Law (Bloomington: Indiana University Press, 1961), p. 249.

[23] Kerin, Op. cit., pp. 18, 19.

[24] Fedden, Op. cit., pp. 143, 144.

[25] Dublin, Op. cit.

> and was absolved, there was no longer any application of the penalty.[26]

Legislation of a church council giving the benefit of the doubt to suicides was discernible in the nineteenth century. The Provincial Council of Progue (1860) declared that if there was doubt whether a person had taken his life in insanity or in desperation, Christian burial was to be given.[27]

## Church Canon Law References

Roman Catholic Church canon law references on suicide deal with suicide under the section on crimes against life, liberty, property, reputation, and morals. A person who has committed a deliberate act of suicide is denied ecclesiastical burial except when the suicide results from nervous or mental derangement.[28] If suicidal persons are clerics, they are to be suspended from their offices.[29] In suicide attempt (trying to kill oneself by shooting, poison, hanging, or any other method, even though the attempt does not result in a wound of any kind), the act is termed a frustrated crime.[30] Canon law also extends to a

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[26] Kerin, _Op_. _cit_., p. 52.

[27] _Ibid_., pp. 74, 75.

[28] T. Lincoln Bouscaren, Adam C. Ellis, Francis N. Korth, _Canon Law_ (Milwaukee: Bruce, 1963), p. 689.

[29] _Ibid_., p. 928.

[30] The term, frustrated crime, is defined thus:

> One who did acts or omissions which by their nature contribute to a crime, but who did not complete the crime, either because he changed his mind or because he lacked adequate means to complete it, commits an attempt at crime (c. 2212. n. 1). When all acts or ommissions which by their nature conduce to the crime and are sufficient to complete it are provided, but for some other reason beside the will of

prohibition of books favoring suicide.[31] Usually the nature of the suicidal act is evaluated in terms of various canon laws (985.5; 1241.1,3; 1399.8; 2212.2,3; 2350.2). Christian burial is denied when there is evidence that the deceased was fully responsible for the deliberate and notorious act. For example, the act of suicide in a state of intoxication is not a proper case for the penal law. In this instance, moral responsibility is not sufficient to justify the privation of Christian burial. However, if there was proof that the deceased became intoxicated in order to commit suicide, Christian burial would be denied the individual.[32] In other words, intention plays an important part in the determination of a deliberate act. Of course, insanity must be proven. In case of doubt concerning insanity, ecclesiastical authorities accept any sign of its presence from the testimony of doctors, relatives or those who are qualified to give such evidence.[33] However, most people consider suicide itself to be a sign of mental disorder.[34]

## III. PASTORAL PRACTICE

Civil legislation followed the lead of canon law in strong prohibitions against suicide.[35] Desecration of the corpse of a suicide

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the agent, they fail to produce their effect, the attempt at crime is properly called a frustrated crime (c. 2212.2).

[31] Bouscaren, Op. cit., 789.

[32] Kerin, Op. cit., pp. 202, 204.

[33] Ibid., pp. 204, 205.

[34] Ibid., p. 205.

[35] Fedden, Op. cit., pp. 185, 186.

was standard practice by civil authorities. Dublin described this practice when he wrote:

> Sometimes the body was dragged through the streets by the feet, face downward, and hung on the public gallows. Sometimes the heart was removed; sometimes it was left in place, but a stake was driven through it as a mark of disrespect. Frequently the body was removed from the house not through the ordinary doorway but through a special opening under the threshold or elsewhere, or it was dragged out through a window, perhaps as a hangover of primitive superstition which feared that a malevolent ghost would reenter the house.[36]
>
> In some places, the suicide was buried in the spot where he ended his life; frequently the body was left unburied in the place of public execution, to be devoured by birds of prey. In some parts of Europe, the presence of a suicide's body was supposed to make barren the earth with which it came in contact, or to produce hailstones or tempests or draught.[37]

Much of the practice toward the corpse of a suicide had definite religious overtones of superstition. For example, a custom in England prescribed that the body should enter the churchyard for burial by the wall and not through the gate.[38] Although the clergy did not openly engage in the desecration of a suicide's corpse, it is interesting to note John Wesley's thoughts on suicide in The Weekly Entertainer (August 16, 1790). In his criticism that court juries constantly bring in the verdict, "insane," regarding suicidal deaths, Wesley suggested that perjury was often committed in these judgments. His answer is quite an astounding proposal for suicide prevention by a clergyman. He said at the end of his open letter:

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[36] Dublin, Op. cit., p. 120.

[37] Ibid., pp. 120, 121.

[38] Fedden, Op. cit., p. 139.

> But how can this vile abuse of the law be prevented, and the execrable curse effectually discouraged?
>
> By a very easy method--we read in ancient history, that at a certain period, many of the women in Sparta murdered themselves. This frenzy increasing, a law was made, that the body of every woman that killed herself should be exposed naked in the streets. The frenzy ceased at once.
>
> Only let a law be made, and vigorously executed, that the body of every self-murderer, lord or peasant, shall be hanged in chains, and the English frenzy will ceast at once.[39]

However, English civic authority rarely desecrated the corpse of a suicide by the end of the seventeenth century. While there was a law which confiscated a suicide's property and possessions, the crown became more lenient and waived its rights in favor of a suicide's family and dependents.[40] By 1770, indignities done to the body or the memory of a suicide were rare in England and France. By 1789, the civil law on suicide was a dead letter, and the denial of Christian burial was the only remaining penalty. Although there was a brief demand for legal penalties against suicide in 1820 with the rise of Louis XVIII in France, liberal and democratic ideas in the French Republic by 1880 finally forbade discrimination against anyone on burial. The last desecration of the body of a suicide occurred in England in 1823.[41]

## IV. CRITIQUE

The theological position of Augustine establish an absolute principle against suicide for all occasions. Aquinas later incorporated the Augustinian viewpoint in his own systematic theological discussion on suicide. Suicide was termed an unlawful act of self-murder against oneself, against the community, and against God. Thus, the theological approach to the problem of suicide was a general prohibition against the act based on logical argumentation and direct condemnation for all situations except in case of a direct command from God. Norman St. John-Stevas summarized the theology of the old model when he said:

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[39] John Wesley, "On Suicide," The Weekly Entertainer (August 16, 1790), pp. 148, 149.

[40] Fedden, Op. cit., p. 193.

[41] Ibid., pp. 226, 227, 230, 264.

> The Augustinian-Thomist position remains that of orthodox Catholicism, and indeed that of Christianity in general. Suicide is condemned as a violation of the fifth (sixth) commandment, as contrary to nature, a usurpation of God's prerogative, and a social wrong. Exclusion of repentance is also a constantly given reason for Christian condemnation.[42]

From a practical standpoint the church expressed itself in the denial of Christian burial rites for suicidal death. A series of pronouncements against suicide was initiated by church councils in the fifth century and was later codified into canon law. Rather than a meaningful commentary on the situational dilemma of the suicidal person, the church sought to prevent suicide through a portrayal of ecclesiastical rejection at the time of death. Later exceptions were made for the suicide of insane persons, but again the law of the church concerned itself with distinctions between sane and insane acts of suicide. Seemingly the church disregarded the victim's immediate cry for help. However, the old model based on fear of punishment had a preventive influence during the Middle Ages. Dublin pointed out:

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[42] Norman St. John-Stevas, The Right to Life (New York: Holt, Rinehart and Winston, 1963), p. 61.

> In spite of these relatively infrequent sporadic outbreaks, religious prohibition acted as a strongly deterring influence when Church and State were inseparable. Bitter religious opposition, the force of condemnatory public opinion, and the severe penalties of the law were so effective that few individuals had the temerity to take their own lives.[43]

But did this means of suicide prevention justify the intended end? An extreme example was the desecration of a suicidal corpse. Undoubtedly the church tolerated such a practice although it was executed by secular authority. Even John Wesley advocated abuse of the body in order to prevent suicide.

John Donne in his book, Biathonatos (1608), was the first Christian writer to state that the circumstances of a suicidal case must be taken into consideration.[44] On the one hand, he affirmed with Augustine that suicide cannot be justified to avoid sin or for self-interest. But, on the other hand, the ban should not be applied dogmatically to every act of self-killing.[45]

With the appearance of John Donne's observations on suicide, the old model of the church gradually lost its influence under successive critics and through an emerging separation of Church and State.[46] It did not remain in dialogue with changing medical research on the matter. As Norman St. John-Stevas pointed out:

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[43] Dublin, Op. cit., p. 123.

[44] Fedden, Op. cit., p. 182.

[45] Ibid., pp. 135, 136.

[46] Ibid., pp. 135-284.

> Insanity has always been considered to absolve the suicide from guilt, but apart from this exception, the Church did not take into account the causes of suicide. Such neglect is not surprising in view of past ignorance of the complexity of suicidal acts and paucity of medical knowledge. This knowledge, despite recent advances, is still limited, but its existence raises the problem whether the traditional Christian attitude to suicide is one on which contemporary social and legal policy can be based.[47]

It is our basic contention that the old model on suicide associated with the church must be up-dated by contemporary changes and a revised model must be shaped by those interested in suicide research and religion.

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[47] St. John-Stevas, The Right to Life, pp. 70-71.

# CHAPTER III

# CONTEMPORARY CHANGES:
# PROTESTANT THEOLOGICAL ETHICS

The aim of this chapter is three-fold in nature: 1) theoretical: to survey contemporary theological views on suicide by major theologians, notably Dietrich Bonhoeffer and Karl Barth; 2) empirical: to report the statistical findings of a questionnaire surveying the theological views on suicide of three-hundred and twenty-three Protestant clergymen; and 3) creative: to present theological ethics of four contemporary thinkers, (Paul Lehmann, Joseph Fletcher, Paul Ramsay, and H. Richard Niebuhr), and to apply their ethical positions to the problem of suicide. Such theological developments will be integrated into a meaningful whole with subsequent findings in the area of pastoral counseling.

## I. CONTEMPORARY THEOLOGICAL VIEWS ON SUICIDE

Augustine condemned suicide as a violation of the commandment, 'Thou shalt not kill.' Aquinas later argued that self-destruction was a mortal sin against natural law and love, community, and God. In our age Dietrich Bonhoeffer and Karl Barth have been the two main spokesmen on suicide. We will later consider how their views differ from the theology of the Old Model.

### Bonhoeffer

The ethics of Dietrich Bonhoeffer on suicide involves a discussion of the preservation of bodily life as a gift from God.[1] In his brief treatment of suicide Bonhoeffer asserts that man has the relative freedom to accept his life or to destroy it.[2] The crucial issue pertains to the true or mistaken use of freedom. On the one hand, God guarantees the right to human life. According to God's will, the body is to be preserved against intentional injury, violation, and killing. Thus, God values life to the extent that there is no life that is not worth living. Therefore the proper use of freedom is to affirm life bestowed by God.[3] On the other hand, the destruction of life is the abuse of this relative freedom. The first right of man is to safeguard bodily life since all rights are extinguished by death. Bonhoeffer particularly condemns arbitrary killing where innocent life is deliberately destroyed. He maintains that this is contrary to the preservation of life. However, man is innocent when he does not engage in conscious attack upon the life of another. An example would be the killing of a criminal who has done injury to another person.[4]

The examination of the suicide issue assumes that the 'preservation of bodily life' principle has direct application to a consideration of the meaning, 'destruction of life.' Bonhoeffer points out that a self-destructive act is evaluated according to human intention. Man is allowed to sacrifice his life for some higher good.[5] Bonhoeffer stressed: "Without freedom to sacrifice one's life in death, there can be no freedom toward God, there can be no human life."[6] However, the abuse of this freedom is termed suicide when man becomes the master of his own destiny.[7] There is no sense of self-sacrifice involved. Rather, man seeks death to avoid defeat and to rob fate of its victory. The suicidal person endeavors to justify his manhood in an ultimate sense.[8] From an existential interpretation suicide is an act of despair. It is an attempt to give final meaning to a meaningless life.[9]

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[1] Dietrich Bonhoeffer, Ethics, (New York: Macmillan, 1955), pp. 112, 122.

[2] Ibid., p. 122.

[3] Ibid., pp. 79-128.

[4] Ibid., pp. 101-122.

[5] Ibid., p. 122.

Apart from this description, suicide is a sin, a lack of faith, according to Bonhoeffer. It is neither an act of self-sacrifice for a higher good nor an acknowledgement of the divine gift, the preservation of life. The act of suicide fails to consider God who alone has the final right over life. From the prospective of proclamation the message of the Bible is the summons of repentance and mercy to the suicide. Even if there is personal torment to the extent of suicide, Bonhoeffer asserts that there must be an affirmation of the preservation of life in the form of commitment to God.[10]

Turning from the general principle, the preservation of life, Bonhoeffer evaluates the motive factor for particular types of suicidal cases. According to Bonhoeffer one can hardly distinguish between self-sacrifice and self-murder in some instances. Confronted by these ambiguities he pleads for the suspension of judgment. However, there are clear examples of permissible self-sacrifice: when there is the possible betrayal of country, family, or friends in time of war; when a person risks his life to save another. Outside of these exceptions Bonhoeffer condemns suicide when it is motivated to solve personal calamity and temptation.[11]

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[6] Ibid.

[7] Ibid.

[8] Ibid., pp. 122-123.

[9] Ibid., p. 123.

[10] Ibid., pp. 123-125.

In conclusion, Bonhoeffer acknowledges the real danger of suicide for the Christian believer. There may be hatred over personal imperfections, grief over frustrations in life, and doubt over the meaninglessness of life. In these predicaments he points out the available religious resources:

> Help can come only from the comfort of grace and from the power of brotherly prayer. It is not the right to life that can overcome this temptation to suicide, but only the grace which allows a man to continue to live in the knowledge of God's forgiveness.[12]

From the viewpoint of Dietrich Bonhoeffer the grace and mercy of God will embrace and sustain a suicide.

## Barth

The topic of suicide is a part of the section, "The Protection of Life," which is under the heading, "Freedom For Life" in Church Dogmatics Volume III, Part Four. The problem of suicide arises from the implications of the protection of life.[13] To protect and to maintain life is to understand the meaning of the Biblical commandment,

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[11] Ibid., pp. 125-127. [12] Ibid., p. 128.

[13] Karl Barth, Church Dogmatics (Edinburgh: T. & T. Clark, 1961), III:4, pp. 397-413.

"Thou shalt not kill." The positive implication of the command is the respect of human life as a loan from God. To respect life is to abstain from the destruction of life. As the Creator of this life and the Giver of eternal life God has freely bestowed human life to man. Life belongs to God. The command of God is that man should take care of his life.[14]

Because life is a loan from God to man for His service, God may command man to sacrifice his life. Such an act depends on the obedience of man to God. Suicide is clearly distinguished by Karl Barth from the sacrifice of life. In his temporal existence man can only properly dispose of his life when God commands him. Otherwise, the act freedom assumes the form of human glorification when man exercises his own sovereignty over himself. Therefore, suicide is rebellion against God who has the final authority over life and death.[15]

In his exposition of the problem, Barth addresses the suicidal condition. There is forgiveness for suicide, but God's forgiveness is no excuse for sin. In his situation the suicide stands alone in the darkness of affliction and the dreadful void. God is hidden from him as his God. The self-destructive person as a sovereign does not know what to do with his sovereignty. He plays with the possibility of terminating his existence. Moral prohibitions are not sufficient means of prevention. Clearly Karl Barth is a theologian who is sensitive to the ethical dilemma of the suicide. For Barth the truth of the Gospel is the message of God: Thou mayest live. Man is not alone, but God surrounds him on every side. God is gracious to him. Man can simply accept that God alone is sovereign and bears the responsibility for his life. Then man can live in freedom. Barth reinforces this message via the Bible. Saul, Ahithophel, and Judas are examples of suicides who asserted their own sovereignty over God. The true Biblical contribution to the problem of suicide is the message of God's grace as well as the cross and resurrection of Christ which expiate the sin of rebellion.[16]

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[14] Ibid., III:4, pp. 397-401. [15] Ibid., III:4, pp. 402-405.

Of course God may ask a man to give up his life. According to Barth, this exceptional case is not only impossible but rare and extraordinary. Generally we cannot decide these situations but must respect life. In summary, Barth reiterates that suicide is self-murder unless man is ordered by God to kill himself. God may forgive the suicide but the act of suicide is still a sin.[17]

## Assessment

The approaches of Bonhoeffer and Barth on the topic of suicide signify theological reaffirmations as well as methodological departures within the church. Augustine, Aquinas, Bonhoeffer, and Barth agree that the command, Thou shalt not kill, is applicable to the problem of suicide. All affirm in varying degrees that the sovereignty of God extends to the authority over life and death. Furthermore, there is general consensus that the only exceptions for suicide are in the interest of public justice or for a higher good and in obedience to the command of God. In other cases, suicide is judged a sin.

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[16] Ibid., III:4, pp. 405-410. [17] Ibid., III:4, pp. 410-413.

However, wide differences prevail in other areas of discussion. Augustine appeals to virtue, the sanctity of the soul, in order to sustain a person from outward circumstances which may prompt suicidal behavior. Aquinas argues that suicide violates the principles of natural law, social obligation, and human subjugation to God. In contrast, Bonhoeffer and Barth focus on the meaning of life in the suicide problem. Rather than solely traditional restrictions, Bonhoeffer explores the implications of the preservation of life as a divine gift to man. He observes that suicide is a mistaken use of relative freedom and that true freedom is the affirmation of life bestowed by God. Similarly, Barth interprets the positive meaning of the protection of life. It is the respect of life as a loan from God. Moreover, Bonhoeffer and Barth conclude with the descriptive condition of the suicidal person as well as the application of the gospel to the situation.

From this assessment one may infer that there has been a shift from an absolute condemnation of suicide toward an understanding of the suicidal person. With the appearance of Bonhoeffer and Barth, it is imperative to consider the viewpoints of parish clergymen and modern expressions of theological ethics. Only then can an adequate revision of a theology on suicide be devised for the church.

## II. STATISTICAL STUDY

Theological ethics is not only the task of theologians but it is also the responsibility of parish ministers who apply theological insights in their daily ministries to persons. Contemporary changes regarding a theology on suicide are now checked by the parish viewpoints of clergymen who are members of major Protestant denominations. A statistical questionnaire was designed to survey theological views on suicide as well as pastoral counseling experiences regarding suicidal persons.

## Theological Ethics Survey

Three-hundred and twenty-three Protestant clergymen responded to the statistical questionnaire on theological views and pastoral counseling experiences regarding suicide. The results are on Table A. The predominant denominations were Methodist, Evangelical United Brethren, African Methodist-Episcopal (30%); Presbyterian, Reformed (19%); United Church of Christ, Congregational (11%); and Disciples of Christ (11%). Other groups were Lutheran (9%); Baptist (8%); Episcopal (5%); Independent and Miscellaneous (community churches, Salvation Army, Quaker, Nazarene, Swedenborgan, Penecostal, Church of Christ, Christian Missionary Alliance, Unitarian-Universalist, Seventh-Day Adventist) (4%); Church of The Brethren (2%); and no answers (1%).

Concerning the specific theological statements on suicide, nearly half of the clergymen were divided over the three main propositions against suicide stated by Aquinas. On the statement, "Suicide is a sin because it does injury to the community," the same number agreed (37%) as disagreed (37%). Likewise, those who were uncertain (13%) equalled those who gave no answers. Regarding the proposition, "Suicide is a sin because it violates the prerogative of God," there was a slight tendency to agree (46%), but there was substantial disagreement (34%). There were only a few uncertain (9%) and only slightly more who gave no answers (11%). The sentence, "Suicide is a sin because it is contrary to natural law and love," also tended to fall into the same pattern of agreement (42%) and disagreement (32%). There were about the same percentage uncertain (11%) as gave no answers (15%).

There might have been an equal amount of disagreement and agreement in the above answers because clergymen recognize that suicide is not explicitly regarded as a sin in scripture. In response to the statement, "Suicide is not a sin because the Bible no where states this," there was substantial disagreement (58%) with minimal uncertainty (15%) and no answers (18%). Agreement was insignificant (9%). Yet at the same time when the three statements given by Aquinas were tabulated altogether, 34% agreed with none of the statements, while 29% agreed with all, 14% agreed with two, and 15% agreed with one. Only a small proportion had no answers to all the statements (7%).

Based on these findings Protestant ministers tend toward a modification of the Aquinas viewpoint on suicide as a sin.

Further movement away from the traditional view of suicide is seen in the areas of ecclesiastical pronouncements and denial of burial rites. These Protestant ministers felt that a strong ecclesiastical pronouncement was not a deterrent against suicide. There was a substantial disagreement (58%) against ecclesiastical pronouncement as a preventive factor against suicide, although agreement (11%) and uncertains (19%) must be considered. No answers were small (11%). Of course, Protestant clergymen operate from a free church tradition. A study of Catholic priests might reveal that within their structure an ecclesiastical pronouncement against suicide has significant influence over their parishioners. Furthermore, there was overwhelming agreement that burial rites should be extended to a rational person who committed suicide (agreement 84%, uncertainty 8%, disagreement 2%, no answer 6%) as well as to a mentally unbalanced person who killed himself (agreement 93%, uncertainty 2%, disagreement 1%, no answers 4%). Again there might have been different response from Catholic clergymen because there are church laws regulating burial rites of rational and mentally-ill suicides. Along the traditional-historical background, the statements, "Religion in terms of the promised after-life may encourage suicide," referred to martyrdom as a pretext for suicide. A majority of the Protestant clergy disagreed (82%) while only a few agreed (3%), were uncertain (7%) or did not answer (7%).

These findings tended to show that Protestant clergymen believed an ecclesiastical pronouncement as a deterrent against suicide was fairly ineffective and that full burial rites should be extended to suicides by Protestants. The connection between martyrdom and suicide seemed to be nil for these Protestants.

There is further evidence of changes in theological views. Suicide was regarded as a forgivable sin by a majority of the Protestant clergymen (66%), while there were some uncertains (16%) and minimal disagree (8%) and no answers (9%). Consideration was given to the situation aspect of suicide, specifically that God may give man the freedom and permission to destroy himself. Agreements (28%) and uncertains (25%) must be seen in relation to disagreements (39%). There were only 10% no answers. A space was left for the elaboration of differing views. Although most Protestant clergymen (82%) did not respond, some (18%) took time to do this. Answers differed widely. Many (5%) re-defined the concept of suicide in terms of separation, a tragic illness, a question of sickness, simply doing wrong, self-alienation or a broken relationship. Others (6%) confined themselves to a detailed description of suicide as a struggle for hope, for regaining self-esteem, for an awareness of God's love and presence; as an affirmation of man's sacred life and suicide as a way out of a meaningless life; or some evaluation of the suicidal situation. There were scattered comments dealing with cultural-environmental characteristics of suicide (1%); the paradox of suicide as a wrong and divine forgiveness (1%); a substitution of the word, sin, for such phrases as a tragic use of freedom, non-rational (1%); suicide as a legitimate good in some cases (1%); suicide as not a sin (2%); religion as health in light of suicide (1%); and the motive for suicide (1%).

No specific theological position on suicide could be established from the specific answers to all the questions. Only 6% could be considered conservative in their theological views on suicide. The majority of clergymen were either moderate conservative (31% or moderate liberal (28%). Several could be called liberal (11%) in their theological stance on suicide. Many could not be determined (25%) because they did not answer all the statements in the theological section of the questionnaire.

In brief, the survey of the theological ethics on suicide of three-hundred and twenty-three Protestant clergymen tended to show some dissatisfaction with Aquinas' theology on suicide, and an understanding of suicide in terms of existential and mental-illness concepts. There was leniency toward suicides in terms of forgiveness, burial rites, and situational factors.

## TABLE A

## THEOLOGICAL ETHICS SURVEY

| IBM Card Column | | No. | % |
|---|---|---|---|
| 1. | Case Number | 323 | 100 |
| 2. | | | |
| 3. | | | |
| 4. | Sex | | |
| | 1. Male | 323 | 100 |
| | 2. Female | 0 | 0 |
| 5. | Age | | |
| | 1. 20-29 | 16 | 4 |
| | 2. 30-39 | 96 | 30 |
| | 3. 40-49 | 98 | 30 |
| | 4. 50-59 | 68 | 21 |
| | 5. 60 and over | 36 | 11 |
| | 6. No Answer | 9 | 3 |
| 6. | Denomination | | |
| | 1. Presbyterian, Reformed | 62 | 19 |
| | 2. Methodist, Evangelical United Brethren African Methodist-Episcopal | 97 | 30 |
| | 3. Lutheran | 29 | 9 |
| | 4. Episcopal | 15 | 5 |
| | 5. United Church of Christ, Congregational | 35 | 11 |
| | 6. Disciples of Christ | 34 | 11 |
| | 7. Baptist | 27 | 8 |
| | 8. Church of the Brethren | 7 | 2 |
| | 9. Miscellaneous (e.g. community churches, Salvation Army, Quakers, Nazarene, Swedenborgian, Pentecostal, Seventh Day Adventist, Church of Christ, Unitarian-Universalist) | 14 | 4 |
| | 0. No Answer | 3 | 1 |
| 7. | Education | | |
| | 1. 0 | 0 | 0 |
| | 2. 1- 2 years | 3 | 1 |
| | 3. 3- 4 years | 3 | 1 |
| | 4. 5- 6 years | 12 | 4 |
| | 5. 7 years | 108 | 33 |
| | 6. 8- 9 years | 142 | 44 |
| | 7. 10 years and over | 53 | 16 |
| | 8. No Answer | 2 | 1 |

TABLE A (Continued)

| | No. | % |
|---|---|---|
| 8. Pastoral Clinical Training | | |
| 1. 0 | 173 | 54 |
| 2. 1- 6 weeks | 52 | 16 |
| 3. 7-12 weeks | 27 | 8 |
| 4. 13-18 weeks | 18 | 6 |
| 5. 19-24 weeks | 7 | 2 |
| 6. 25-30 weeks | 3 | 1 |
| 7. 31 weeks | 24 | 7 |
| 8. No Answer | 19 | 6 |
| 9. Years served in parish ministry in Los Angeles County | | |
| 1. 0- 1 year | 33 | 10 |
| 2. 2- 5 years | 110 | 34 |
| 3. 6- 9 years | 65 | 20 |
| 4. 10-19 years | 85 | 26 |
| 5. 20-29 years | 20 | 6 |
| 6. 30 years and plus | 6 | 2 |
| 7. No Answer | 4 | 1 |
| 10. Years served in parish ministry | | |
| 1. 0- 1 year | 3 | 1 |
| 2. 2- 5 years | 24 | 7 |
| 3. 6- 9 years | 40 | 12 |
| 4. 10-19 years | 92 | 28 |
| 5. 20-29 years | 70 | 22 |
| 6. 30 years and over | 60 | 19 |
| 7. No Answer | 34 | 11 |
| 11. Number of persons counseled who threatened suicide in Los Angeles County in 1965 | | |
| 1. 0 | 90 | 28 |
| 2. 1- 2 | 120 | 37 |
| 3. 3- 4 | 39 | 12 |
| 4. 5- 7 | 16 | 4 |
| 5. 8-10 | 7 | 2 |
| 6. 11 and over | 6 | 2 |
| 7. No Answer | 45 | 14 |

TABLE A (Continued)

| | No. | % |
|---|---|---|
| 12. Number of persons counseled who threatened suicide in parish ministry in Los Angeles County | | |
| 1. 0 | 52 | 16 |
| 2. 1- 2 | 65 | 20 |
| 3. 3- 4 | 41 | 13 |
| 4. 5- 7 | 42 | 13 |
| 5. 8-10 | 23 | 7 |
| 6. 11 and over | 41 | 13 |
| 7. No Answer | 59 | 18 |
| 13. Number of persons counseled who threatened suicide in total parish ministry | | |
| 1. 0 | 32 | 10 |
| 2. 1- 2 | 34 | 11 |
| 3. 3- 4 | 45 | 14 |
| 4. 5- 7 | 41 | 13 |
| 5. 8-10 | 34 | 11 |
| 6. 11-13 | 15 | 5 |
| 7. 14-16 | 15 | 5 |
| 8. 17-19 | 4 | 1 |
| 9. 20 and over | 39 | 12 |
| 0. No Answer | 64 | 20 |
| 14. Number of persons counseled who attempted suicide in Los Angeles County in 1965 | | |
| 1. 0 | 167 | 52 |
| 2. 1- 2 | 93 | 29 |
| 3. 3- 4 | 10 | 3 |
| 4. 5- 7 | 1 | .3 |
| 5. 8-10 | 0 | 0 |
| 6. 11 and over | 0 | 0 |
| 7. No Answer | 52 | 16 |
| 15. Number of persons counseled who attempted suicide in parish ministry in Los Angeles County | | |
| 1. 0 | 110 | 34 |
| 2. 1- 2 | 90 | 28 |
| 3. 3- 4 | 39 | 12 |
| 4. 5- 7 | 14 | 4 |
| 5. 8-10 | 3 | 1 |
| 6. 11 and over | 5 | 2 |
| 7. No Answer | 62 | 19 |

TABLE A (Continued)

| | No. | % |
|---|---|---|
| 16. Number of persons counseled who attempted suicide in total parish ministry | | |
| 1. 0 | 76 | 24 |
| 2. 1- 2 | 80 | 25 |
| 3. 3- 4 | 55 | 17 |
| 4. 5- 7 | 25 | 8 |
| 5. 8-10 | 8 | 2 |
| 6. 11 and over | 11 | 3 |
| 7. No Answer | 68 | 21 |
| 17. Number of persons counseled who evenutally committed suicide in Los Angeles County in 1965 | | |
| 1. 0 | 235 | 73 |
| 2. 1- 2 | 31 | 10 |
| 3. 3- 4 | 1 | .3 |
| 4. 5- 7 | 0 | 0 |
| 5. 8-10 | 0 | 0 |
| 6. 11 and over | 0 | 0 |
| 7. No Answer | 56 | 17 |
| 18. Number of persons counseled who eventually committed suicide in parish ministry in Los Angeles County | | |
| 1. 0 | 201 | 62 |
| 2. 1- 2 | 57 | 18 |
| 3. 3- 4 | 7 | 2 |
| 4. 5- 7 | 1 | .3 |
| 5. 8-10 | 0 | 0 |
| 6. 11 and over | 0 | 0 |
| 7. No Answer | 57 | 18 |
| 19. Number of persons counseled who eventually committed suicide in total parish ministry | | |
| 1. 0 | 167 | 52 |
| 2. 1- 2 | 77 | 24 |
| 3. 3- 4 | 15 | 5 |
| 4. 5- 7 | 8 | 2 |
| 5. 8-10 | 2 | 1 |
| 6. 11 and over | 1 | .3 |
| 7. No Answer | 53 | 16 |

TABLE A (Continued)

| | No. | % |
|---|---|---|
| 20. Number of funerals for suicide in Los Angeles County in 1965 | | |
| 1. 0 | 161 | 50 |
| 2. 1- 2 | 103 | 32 |
| 3. 3- 4 | 12 | 4 |
| 4. 5- 7 | 4 | 1 |
| 5. 8-10 | 0 | 0 |
| 6. 11 and over | 2 | 1 |
| 21. Number of funerals for suicide in parish ministry in Los Angeles County | | |
| 1. 0 | 111 | 34 |
| 2. 1- 2 | 64 | 20 |
| 3. 3- 4 | 28 | 9 |
| 4. 5- 7 | 30 | 9 |
| 5. 8-10 | 5 | 2 |
| 6. 11 and over | 9 | 3 |
| 7. No Answer | 76 | 24 |
| 22. Number of funderals for suicide in total parish ministry | | |
| 1. 0 | 82 | 25 |
| 2. 1- 2 | 61 | 19 |
| 3. 3- 4 | 29 | 9 |
| 4. 4- 7 | 43 | 13 |
| 5. 8-10 | 13 | 4 |
| 6. 11 and over | 24 | 7 |
| 7. No Answer | 71 | 22 |
| 23. Number of families of persons counseled who committed suicide in Los Angeles County in 1965 | | |
| 1. 0 | 159 | 49 |
| 2. 1- 2 | 70 | 22 |
| 3. 3- 4 | 9 | 3 |
| 4. 5- 7 | 1 | .3 |
| 5. 8-10 | 0 | 0 |
| 6. 11 and over | 0 | 0 |
| 7. No answer | 84 | 0 |

TABLE A (Continued)

| | | No. | % |
|---|---|---|---|
| 24. | Number of families of persons counseled who committed suicide in Los Angeles County | | |
| | 1. 0 | 123 | 26 |
| | 2. 1- 2 | 58 | 18 |
| | 3. 3- 4 | 22 | 7 |
| | 4. 5- 7 | 15 | 5 |
| | 5. 8-10 | 8 | 2 |
| | 6. 11 and over | 4 | 1 |
| | 7. No Answer | 94 | 29 |
| 25. | Number of families of persons counseled who committed suicide in total parish ministry | | |
| | 1. 0 | 92 | 28 |
| | 2. 1- 2 | 55 | 17 |
| | 3. 3- 4 | 27 | 8 |
| | 4. 5- 7 | 28 | 9 |
| | 5. 8-10 | 6 | 2 |
| | 6. 11 and over | 20 | 6 |
| | 7. No Answer | 95 | 30 |
| 26. | Referral to an agency or professional person outside or within the church | | |
| | 1. Yes, outside the church | 93 | 29 |
| | 2. Yes, within the church | 13 | 4 |
| | 3. Both | 80 | 25 |
| | 4. No | 60 | 19 |
| | 5. No Answer | 77 | 24 |
| 27. | Aware of the existence of the Los Angeles Suicide Prevention Center | | |
| | 1. Yes | 191 | 59 |
| | 2. No | 77 | 24 |
| | 3. No Answer | 55 | 17 |
| 28. | If aware of Los Angeles Suicide Prevention Center, referral of counselees | | |
| | 1. Yes | 51 | 16 |
| | 2. No | 128 | 40 |
| | 3. No Answer | 64 | 20 |
| | 4. No (on question 27) | 80 | 25 |

TABLE A (Continued)

| | | No. | % |
|---|---|---|---|
| 29. | Number of counselees referred to Los Angeles Suicide Prevention Center in 1965 | | |
| | 1. 0 | 137 | 42 |
| | 2. 1- 2 | 34 | 11 |
| | 3. 3- 4 | 4 | 1 |
| | 4. 5- 7 | 0 | 0 |
| | 5. 8-10 | 0 | 0 |
| | 6. 11 and over | 1 | .3 |
| | 7. No (on question 27) | 77 | 24 |
| | 8. No Answer | 80 | 25 |
| 30. | Certainty about counseling suicidal cases | | |
| | 1. I feel certain I can do a helpful job, with or without outside referral | 48 | 15 |
| | 2. I feel somewhat certain | 116 | 40 |
| | 3. I don't feel certain at all | 78 | 24 |
| | 4. No Answer | 80 | 25 |
| 31. | Suicide is a sin because by killing himself, he injures the community of which he is a part. | | |
| | 1. Agree (conservative) | 119 | 37 |
| | 2. Uncertain | 43 | 13 |
| | 3. Disagree (liberal) | 119 | 37 |
| | 4. No Answer | 42 | 13 |
| 32. | Suicide is a sin because it assumes the prerogative of God who alone has the right to give life and take it away | | |
| | 1. Agree (conservative) | 148 | 46 |
| | 2. Uncertain | 29 | 9 |
| | 3. Disagree (liberal) | 109 | 34 |
| | 4. No Answer | 37 | 11 |
| 33. | Suicide is a sin because every man should love himself and therefore suicide is contrary to natural law and to love. | | |
| | 1. Agree (conservative) | 137 | 42 |
| | 2. Uncertain | 34 | 11 |
| | 3. Disagree (liberal) | 102 | 32 |
| | 4. No Answer | 50 | 15 |

TABLE A (Continued)

| | No. | % |
|---|---|---|
| 34. Suicide is not a sin because the Bible nowhere explicitly states this. | | |
| 1. Agree (liberal) | 28 | 9 |
| 2. Uncertain | 48 | 15 |
| 3. Disagree (conservative) | 188 | 58 |
| 4. No Answer | 59 | 18 |
| 35. I believe that a strong ecclesiastical pronouncement against suicide deters parishioners from taking their lives. | | |
| 1. Agree (conservative) | 36 | 11 |
| 2. Uncertain | 61 | 19 |
| 3. Disagree (liberal) | 189 | 58 |
| 4. No Answer | 37 | 11 |
| 36. I would give the full burial rites of my church to a rational person who has committed suicide. | | |
| 1. Agree (liberal) | 271 | 84 |
| 2. Uncertain | 26 | 8 |
| 3. Disagree (conservative) | 7 | 2 |
| 4. No Answer | 19 | 6 |
| 37. I would give the full burial rites of my church to a mentally unbalanced person who has committed suicide. (Some religious bodies will not give the full burial rites unless the suicidal dead person is seriously disturbed enough to be called mentally ill.) | | |
| 1. Agree (liberal) | 300 | 93 |
| 2. Uncertain | 5 | 2 |
| 3. Disagree (conservative) | 2 | 1 |
| 4. No Answer | 16 | 4 |
| 38. Suicide is a forgivable sin because God judges the content of the last hour in the context of the whole. Even a righteous man may be momentarily in the wrong by the act of suicide at the last. | | |
| 1. Agree (liberal) | 217 | 66 |
| 2. Uncertain | 51 | 16 |
| 3. Disagree (conservative) | 25 | 8 |
| 4. No Answer | 30 | 9 |

TABLE A (Continued)

| | | No. | % |
|---|---|---|---|
| 39. | There are situations in which God may actually give man the freedom and permission to destroy himself, so that he cannot be regarded as a suicide in the bad sense. | | |
| | 1. Agree (liberal) | 88 | 28 |
| | 2. Uncertain | 78 | 25 |
| | 3. Disagree (conservative) | 126 | 39 |
| | 4. No Answer | 31 | 10 |
| 40. | I believe that religion encourages suicide because it historically speaks glowingly of an afterlife and often been pessimistic about this world. | | |
| | 1. Agree (liberal) | 10 | 3 |
| | 2. Uncertain | 24 | 7 |
| | 3. Disagree (conservative) | 265 | 82 |
| | 4. No Answer | 24 | 7 |
| 41. | Theological position on suicide conservative (low), moderate (medium), liberal (high) | | |
| | 1. 1- 5 | 0 | 0 |
| | 2. 6-10 | 1 | .3 |
| | 3. 11-15 | 15 | 5 |
| | 4. 16-20 | 100 | 31 |
| | 5. 21-25 | 90 | 28 |
| | 6. 26-30 | 35 | 11 |
| | 7. unable to determine | 82 | 25 |
| 42. | County District | | |
| | 1. Los Angeles | 186 | 58 |
| | 2. Long Beach-Palos Verdes | 31 | 10 |
| | 3. Whittier-Norwalk | 11 | 3 |
| | 4. Claremont-Pomona | 18 | 6 |
| | 5. Pasadena | 24 | 7 |
| | 6. Antelope Valley | 5 | 2 |
| 43. | On Aquinas (questions 31, 32, 33) | | |
| | 1. Agree on all | 94 | 29 |
| | 2. Agree on two | 46 | 14 |
| | 3. Agree on one | 50 | 15 |
| | 4. Agree on none | 111 | 34 |
| | 5. No Answer | 22 | 7 |

TABLE A (Continued)

| | No. | % |
|---|---|---|
| 44. Elaboration of open ended question 26 | | |
| 1. No Answer | 265 | 82 |
| 2. Redefinition of suicide as sin | 15 | 5 |
| 3. Cultural and environmental distinctions | 2 | 1 |
| 4. Paradox: suicide is wrong but there is forgiveness | 2 | 1 |
| 5. Substitution of sin in the concept of suicide | 4 | 1 |
| 6. Descriptive situation | 20 | 6 |
| 7. Suicide is a good | 2 | 1 |
| 8. Suicide is not a sin | 7 | 2 |
| 9. Religion is healthy | 3 | 1 |
| 0. Motive | 3 | 1 |

## Aquinas Theology on Suicide and Other Variables

Those who agreed with all of Aquinas' statements on suicide were between the ages of thirty and fifty-nine (ages 30-39, 29%; ages 40-49, 29%; ages 50-59, 22%). See Table B for further investigation. They were from several denominations (Methodist, Evangelical United Brethren, African Methodist Episcopal, 23%; Presbyterian, Reformed, 19%; Lutheran, 15%). Most of them had seven to nine years of formal education (7 years, 32%, 8-9 years, 41%; 10 years and over, 22%). Over half had no clinical training (64%) while only 15% had one to six weeks of training in a hospital or correctional institution. Years of experience in the parish ministry ranged from ten to thirty years and over (10-19 years, 29%; 20-29 years, 20%; 30 years and over, 20%. There were few counseling opportunities with suicidal persons.

The number of persons counseled with suicidal thoughts ranged from one to ten (1-2 persons, 11%, 3-4 persons, 13%, 5-7 persons, 13%, 8-10 persons, 11%) although some (13%) recorded that they had counseled with 20 or more persons who had mentioned suicide in their total ministry. Counseling experiences with attempted suicides were even less. The number of persons counseled ranged from one to four, (1-2 persons, 28%; 3-4 persons, 14%). Several (21%) indicated no counseling experience with attempted suicides in their total parish ministry. Counseling experience with persons who eventually committed suicide was minimal. About half (52%) of those who agreed with Aquinas on suicide recorded no such experience whereas a number (26%) of ministers said that they had counseling experience with one or two committed suicides. Even in the area of funerals of suicides, one fifth of the ministers in this category reported no funerals (20%), while almost one third reported only one or two funerals (31%). Counseling with families of suicides also showed no experience (24%), one or two families (23%) and three or four families (11%). Regarding referrals outside or within the church, 30% referred outside the church, and 28% used facilities outside and inside the church. General theological position could be termed between conservative (13%) and moderately conservative (61%).

Those who did not agree at all with Aquinas were statistically similar to the preceding group which fully agreed. The age remained similar (30-39 years, 30%; 40-49 years, 32%; 50-59 years, 20%). There was similar response according to denomination: Methodist, Evangelical United Brethren, African Methodist Episcopal, (31%); Presbyterian, Reformed, (22%); and Disciples of Christ, (15%). Educational attainment remained similar to the all-agreed group (7 years, 36%; 8-9 years, 41%; 10 years and over, 15%). Clinical training tended to show a slightly larger percentage of clinically trained persons who disagreed rather than agreed with Aquinas (no training, 47%; 1-6 weeks, 23%; 7-12 weeks 9%; 31 weeks and over, 8%). Years in the parish ministry were from ten to thirty years and over (10-19 years, 31%; 20-29 years, 22%; 30 years and over, 17%).

Counseling contact with suicidal persons showed slightly higher percentages in some categories than those earlier stated by the agreed group: threatened suicides (3-4 persons, 7%; 5-7 persons, 13%; 8-10 persons, 13%; 11-13 persons, 7%); attempted suicides (no persons, 23%; 1-2 persons, 20%; 3-4 persons, 25%); committed suicides (no persons, 44%; 1-2 persons, 31%). There was a slight increase in the number of suicide funerals conducted by ministers of this group (no funerals, 23%; 1-2 funerals, 16%; 5-7 funerals, 20%, compared with 9% in the same category of those who agreed with Aquinas). However, there was less contact with families of suicidal persons (no families 28%, 1-2 families 19%). Referrals outside or within the church revealed about the same percentages compared with the group who agreed with Aquinas (referral outside the church, 31%; referral outside and within the church, 23%). The general theological position on suicide for the disagreed group showed moderately liberal (41%) and liberal (31%) viewpoints.

There were no significant differences between those who agreed with Aquinas and those who did not. The disagreed group had slightly more clinical training and more counseling experience with suicidal persons. But based on the statistics a more liberal theology regarding suicide were not influenced by these two factors.

## TABLE B*

## HOW PROTESTANT MINISTERS DIFFER AMONG THEMSELVES CONCERNING AQUINAS' THEOLOGY ON SUICIDE AND OTHER VARIABLES

Agreement on Aquinas' Theology Question 43

| | Agree on all (94) | | Agree on two (46) | | Agree on one (50) | | Agree on none (111) | | NA (22) | |
|---|---|---|---|---|---|---|---|---|---|---|
| IBM Card Columns | No. | % | No. | % | No. | % | No. | % | No. | % |
| 5. Age | | | | | | | | | | |
| 1. 20-29 | 3 | 3 | 3 | 7 | 2 | 4 | 8 | 7 | 0 | 0 |
| 2. 30-39 | 27 | 29 | 18 | 39 | 12 | 24 | 33 | 30 | 6 | 27 |
| 3. 40-49 | 27 | 29 | 14 | 30 | 15 | 30 | 36 | 32 | 6 | 27 |
| 4. 50-59 | 21 | 22 | 8 | 17 | 13 | 26 | 22 | 20 | 4 | 18 |
| 5. 60 and over | 14 | 15 | 2 | 4 | 7 | 14 | 8 | 7 | 5 | 23 |
| 6. NA | 2 | 2 | 1 | 2 | 1 | 2 | 4 | 4 | 1 | 4 |
| 6. Denomination | | | | | | | | | | |
| 1. Presbyterian | 18 | 19 | 9 | 20 | 6 | 12 | 24 | 22 | 5 | 23 |
| 2. Methodist | 22 | 23 | 14 | 30 | 20 | 40 | 34 | 31 | 7 | 32 |
| 3. Lutheran | 14 | 15 | 5 | 10 | 2 | 4 | 5 | 5 | 3 | 14 |
| 4. Episcopal | 3 | 3 | 1 | 2 | 1 | 2 | 9 | 8 | 1 | 4 |
| 5. United Church | 11 | 11 | 7 | 15 | 4 | 8 | 8 | 7 | 5 | 23 |
| 6. Disciples | 10 | 11 | 3 | 7 | 4 | 8 | 17 | 15 | 0 | 0 |
| 7. Baptist | 10 | 11 | 6 | 13 | 5 | 10 | 5 | 5 | 1 | 4 |
| 8. Brethren | 3 | 3 | 0 | 0 | 1 | 2 | 3 | 3 | 0 | 0 |
| 9. Miscellaneous | 3 | 3 | 1 | 2 | 6 | 12 | 4 | 4 | 0 | 0 |
| 0. NA | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 2 | 0 | 0 |
| 7. Education | | | | | | | | | | |
| 1. 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2. 1-2 years | 0 | 0 | 1 | 2 | 2 | 4 | 0 | 0 | 0 | 0 |
| 3. 3-4 years | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 4 |
| 4. 5-6 years | 3 | 3 | 0 | 0 | 2 | 4 | 5 | 5 | 1 | 4 |
| 5. 7 years | 30 | 32 | 16 | 35 | 13 | 26 | 41 | 36 | 8 | 36 |
| 6. 8-9 years | 38 | 41 | 22 | 48 | 24 | 48 | 46 | 41 | 12 | 54 |
| 7. 10 years and over | 21 | 22 | 7 | 15 | 8 | 16 | 17 | 15 | 0 | 0 |

* See TABLE A for full description of categories

TABLE B (Continued)

| | Agree on all (94) | | Agree on two (46) | | Agree on one (50) | | Agree on none (111) | | NA (22) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % |
| 8. Pastoral Clinical Training | | | | | | | | | | |
| 1. 0 | 60 | 64 | 23 | 50 | 28 | 56 | 52 | 47 | 3 | 14 |
| 2. 1- 6 weeks | 14 | 15 | 7 | 15 | 5 | 10 | 25 | 23 | 1 | 4 |
| 3. 7-12 weeks | 6 | 6 | 4 | 9 | 5 | 10 | 10 | 9 | 2 | 9 |
| 4. 13-18 weeks | 6 | 6 | 4 | 9 | 1 | 2 | 6 | 5 | 1 | 4 |
| 5. 19-24 weeks | 1 | 1 | 1 | 2 | 2 | 4 | 3 | 3 | 0 | 0 |
| 6. 25-30 weeks | 1 | 1 | 5 | 10 | 0 | 0 | 2 | 2 | 0 | 0 |
| 7. 31 weeks and over | 4 | 4 | 0 | 0 | 3 | 6 | 9 | 8 | 3 | 14 |
| 8. NA | 5 | 5 | 2 | 4 | 6 | 12 | 4 | 4 | 2 | 9 |
| 10. Parish Ministry | | | | | | | | | | |
| 1. 0- 1 year | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 2 | 0 | 0 |
| 2. 2- 5 years | 5 | 5 | 6 | 13 | 2 | 4 | 10 | 9 | 1 | 4 |
| 3. 6- 9 years | 12 | 13 | 9 | 20 | 6 | 12 | 12 | 11 | 1 | 4 |
| 4. 10-19 years | 27 | 29 | 13 | 28 | 12 | 24 | 35 | 31 | 5 | 23 |
| 5. 20-29 years | 19 | 20 | 10 | 22 | 12 | 24 | 24 | 22 | 5 | 23 |
| 6. 30 years and over | 19 | 20 | 6 | 13 | 11 | 22 | 19 | 17 | 5 | 23 |
| 7. NA | 12 | 13 | 2 | 4 | 6 | 12 | 9 | 8 | 5 | 23 |
| 13. Threatened Suicides in Total Ministry | | | | | | | | | | |
| 1. 0 | 6 | 6 | 7 | 15 | 9 | 18 | 8 | 7 | 2 | 9 |
| 2. 1- 2 | 10 | 11 | 7 | 15 | 7 | 14 | 7 | 6 | 3 | 14 |
| 3. 3- 4 | 12 | 13 | 4 | 9 | 8 | 16 | 19 | 17 | 2 | 9 |
| 4. 5- 7 | 12 | 13 | 8 | 17 | 6 | 12 | 14 | 13 | 1 | 4 |
| 5. 8-10 | 10 | 11 | 6 | 13 | 1 | 2 | 14 | 13 | 3 | 14 |
| 6. 11-13 | 2 | 2 | 3 | 7 | 1 | 2 | 8 | 1 | 1 | 4 |
| 7. 14-16 | 4 | 4 | 2 | 4 | 1 | 2 | 7 | 6 | 1 | 4 |
| 8. 17-19 | 1 | 1 | 0 | 0 | 0 | 0 | 3 | 3 | 0 | 0 |
| 9. 20 and over | 12 | 13 | 6 | 13 | 7 | 14 | 12 | 11 | 2 | 9 |
| 0. NA | 25 | 27 | 0 | 0 | 10 | 20 | 19 | 17 | 6 | 27 |
| 16. Attempted Suicides in Total Ministry | | | | | | | | | | |
| 1. 0 | 20 | 21 | 14 | 30 | 14 | 28 | 25 | 23 | 3 | 14 |
| 2. 1- 2 | 26 | 28 | 11 | 24 | 14 | 28 | 22 | 20 | 7 | 32 |
| 3. 3- 4 | 13 | 14 | 10 | 22 | 2 | 4 | 28 | 25 | 2 | 9 |
| 4. 5- 7 | 7 | 7 | 4 | 9 | 4 | 8 | 10 | 9 | 0 | 0 |
| 5. 8-10 | 1 | 1 | 2 | 4 | 1 | 2 | 4 | 4 | 0 | 0 |
| 6. 11 and over | 1 | 1 | 3 | 7 | 3 | 6 | 2 | 2 | 2 | 9 |
| 7. NA | 26 | 28 | 2 | 4 | 12 | 24 | 20 | 18 | 8 | 36 |

TABLE B (Continued)

| | Agree on all (94) | | Agree on two (46) | | Agree on one (50) | | Agree on none (111) | | NA (22) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % |
| 19. Committed Suicides in Total Ministry | | | | | | | | | | |
| 1. 0 | 49 | 52 | 28 | 61 | 29 | 58 | 49 | 44 | 11 | 50 |
| 2. 1- 2 | 24 | 26 | 10 | 22 | 5 | 10 | 35 | 31 | 3 | 14 |
| 3. 3- 4 | 4 | 4 | 2 | 4 | 3 | 6 | 4 | 4 | 2 | 9 |
| 4. 5- 7 | 1 | 1 | 2 | 4 | 1 | 2 | 4 | 4 | 0 | 0 |
| 5. 8-10 | 0 | 0 | 1 | 2 | 1 | 2 | 0 | 0 | 0 | 0 |
| 6. 11 and over | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 4 |
| 7. NA | 16 | 17 | 3 | 7 | 10 | 20 | 19 | 17 | 5 | 23 |
| 22. Funerals in Total Ministry | | | | | | | | | | |
| 1. 0 | 19 | 20 | 16 | 35 | 19 | 38 | 26 | 23 | 2 | 9 |
| 2. 1- 2 | 29 | 31 | 8 | 17 | 3 | 6 | 18 | 16 | 3 | 14 |
| 3. 3- 4 | 8 | 9 | 8 | 17 | 3 | 6 | 10 | 9 | 0 | 0 |
| 4. 5- 7 | 8 | 9 | 7 | 15 | 5 | 10 | 22 | 20 | 0 | 0 |
| 5. 8-10 | 3 | 3 | 1 | 2 | 1 | 2 | 7 | 6 | 1 | 4 |
| 6. 11 and over | 5 | 5 | 0 | 0 | 6 | 12 | 10 | 9 | 3 | 14 |
| 7. NA | 21 | 22 | 6 | 13 | 13 | 26 | 18 | 16 | 13 | 59 |
| 25. Families of Suicide in Total Ministry | | | | | | | | | | |
| 1. 0 | 23 | 24 | 19 | 41 | 17 | 34 | 31 | 28 | 2 | 9 |
| 2. 1- 2 | 22 | 23 | 7 | 15 | 4 | 8 | 21 | 19 | 1 | 4 |
| 3. 3- 4 | 10 | 11 | 6 | 13 | 1 | 2 | 8 | 7 | 2 | 9 |
| 4. 5- 7 | 8 | 9 | 5 | 10 | 6 | 12 | 8 | 7 | 1 | 4 |
| 5. 8-10 | 1 | 1 | 1 | 2 | 0 | 0 | 4 | 4 | 0 | 0 |
| 6. 11 and over | 5 | 5 | 1 | 2 | 5 | 10 | 9 | 8 | 0 | 0 |
| 7. NA | 25 | 27 | 7 | 15 | 17 | 34 | 30 | 27 | 16 | 72 |
| 26. Referral | | | | | | | | | | |
| 1. Yes, outside church | 28 | 30 | 14 | 30 | 12 | 24 | 35 | 31 | 4 | 18 |
| 2. Yes, within church | 3 | 3 | 2 | 4 | 1 | 2 | 6 | 5 | 1 | 4 |
| 3. Both | 26 | 28 | 14 | 30 | 13 | 26 | 26 | 23 | 3 | 14 |
| 4. No | 18 | 19 | 9 | 20 | 8 | 16 | 24 | 22 | 1 | 4 |
| 5. NA | 19 | 20 | 8 | 17 | 17 | 34 | 20 | 18 | 13 | 59 |

TABLE B (Continued)

| | Agree on all (94) | | Agree on two (46) | | Agree on one (50) | | Agree on none (111) | | NA (22) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % | No. | % |
| 41. Theological Position | | | | | | | | | | |
| 1. 1- 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2. 6-10 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 |
| 3. 11-15 | 12 | 13 | 3 | 7 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4. 16-20 | 65 | 69 | 20 | 43 | 14 | 28 | 1 | 1 | 0 | 0 |
| 5. 21-25 | 5 | 5 | 18 | 39 | 22 | 44 | 45 | 41 | 0 | 0 |
| 6. 26-30 | 0 | 0 | 0 | 0 | 1 | 2 | 34 | 31 | 0 | 0 |
| 7. Unable to determine | 12 | 13 | 5 | 10 | 12 | 24 | 31 | 28 | 22 | 100 |

## Theological Position on Suicide and Other Variables

There were small differences between liberal, moderate, and conservative groups in age, denomination, years in the parish, counseling with suicidal persons, contacts with families of suicides, referral, and Aquinas theology on Table C. Concerning age, conservatives were between 40-59 years (40-49 years, 38%; 50-59 years, 38%), moderates were distributed evenly between 30-59 years (30-39 years, 29%; 40-49 years, 31%; 50-59 years, 20%), but liberals were younger than conservatives (30-39 years, 38%; 40-49 years, 27%; 50-59 years, 17%). Presbyterians, Reformed (22%); Methodist, Evangelical United Brethren, African Methodist-Episcopal (36%), and Disciples of Christ, (15%) were the predominant groups among liberals. Moderates were more distributed among Methodist, Evangelical United Brethren, African Methodist-Episcopal (27%); Presbyterian, Reformed, (19%); Lutheran, (14%); United Church of Christ, Congregational (11%); and Baptist, (11%). Conservatives were more evenly represented among Lutheran (19%); Methodist, Evangelical United Brethren, African Methodist-Episcopal (19%); Episcopal, (13%); Baptist, (13%); and Independents, (13%). With reference to parish experience, conservatives were equally distributed in the ten to thirty and over years categories (10-19 years; 19%, 20-29 years, 19%; 30 years and over, 19%), moderates also were in these groupings (10-19 years, 29%; 20-29 years, 23%; 30 years and over, 20%), but liberals had less years in the parish (10-19 years, 31%; and 6-9 years, 18%; as well as 20-29 years, 18%).

Counseling experience with suicidal persons revealed that liberals in theology had slightly more contacts with committed suicides than conservatives (conservative, no persons, 63%, 1-2 persons, 19%; moderate, no persons, 56%, 1-2 persons, 21%; liberal, no persons, 52%, 1-2 persons, 25%). But all three groups had approximately the same percentages for threatened suicides (conservative, no persons, 19%, 1-2 persons, 6%, 3-4 persons, 6%, 5-7 persons, 13%; moderate, no persons, 7%, 1-2 persons, 16%, 3-4 persons, 13%, 5-7 persons, 13%; liberal, no persons, 11%, 1-2 persons, 4%, 3-4 persons, 18%, 5-7 persons, 14%). The same trend existed for attempted suicides (conservative, no persons, 19%, 1-2 persons, 19%, 3-4 persons, 19%; moderate, no persons, 25%, 1-2 persons, 28%, 3-4 persons, 14%; liberal, no persons, 26%, 1-2 persons, 24%, 3-4 persons, 22%). Concerning suicidal funerals there were isolated instances of differences but distributions among the three groupings (conservative, no funerals, 38%, 1-2 persons, 19%, 3-4 persons, 6%, 5-7 persons, 13%; moderate, no funerals, 23%, 1-2 persons, 29%, 3-4 persons, 12%, 5-7 persons, 8%; liberal, no funerals, 27%, 1-2 persons, 18%, 3-4 persons, 19%, 5-7 persons, 16%). Counseling families of suicides also pointed to isolated differences but no significant trends (conservative, no families, 50%, 1-2 families, 6%, 3-4 families, 13%; moderate, no families, 26%, 1-2 families, 25%, 3-4 families, 11%; liberal, no families, 31%, 1-2 families, 18%, 3-4 families, 6%). All groups tended toward referrals outside the church (conservative, 19%; moderate, 26%; liberal, 32%) as well as referral outside and inside the church (conservative, 25%; moderate, 26%; liberal, 19%).

There was one instance of reversal. Conservatives (38%) tended to have more education (10 years and over) than liberals (18%) and moderates. All groupings had from seven to nine years of education (conservative, 7 years, 31%, 8-9 years, 25%; moderate, 7 years, 35%, 8-9 years, 46%; liberal, 7 years, 32%, 8-9 years, 45%). Groups were most similar in clinical training (conservative, no training, 50%, 1-6 weeks, 13%, 7-12 weeks, 19%; moderate, no training, 62%, 1-6 weeks, 14%, 7-12 weeks, 4%; liberal, no training, 46%, 1-6 weeks, 19%, 7-12 weeks, 10%). Groups differed concerning Aquinas' theology. Conservative (75%) agreed on all; moderates agreed on all (65%); but liberals (63%) agreed on none.

## TABLE C*

## HOW PROTESTANT MINISTERS DIFFER AMONG THEMSELVES CONCERNING THEOLOGICAL POSITION ON SUICIDE AND OTHER VARIABLES

Different Theological Positions Question 41

| | Low | | Medium | | High | |
|---|---|---|---|---|---|---|
| | 6-15 | | 16-20 | | 21-30 | |
| | (16) | | (100) | | (125) | |
| IBM Card Columns | No. | % | No. | % | No. | % |
| 5. Age. | | | | | | |
| 1. 20-29 | 0 | 0 | 4 | 4 | 9 | 7 |
| 2. 30-39 | 3 | 19 | 28 | 28 | 48 | 38 |
| 3. 40-49 | 6 | 38 | 31 | 31 | 34 | 27 |
| 4. 50-59 | 26 | 38 | 20 | 20 | 21 | 17 |
| 5. 60 and over | 1 | 6 | 14 | 14 | 9 | 7 |
| 6. NA | 0 | 0 | 3 | 3 | 4 | 3 |
| 6. Denomination | | | | | | |
| 1. Presbyterian | 1 | 6 | 19 | 19 | 27 | 22 |
| 2. Methodist | 3 | 19 | 27 | 27 | 45 | 36 |
| 3. Lutheran | 3 | 19 | 14 | 14 | 5 | 4 |
| 4. Episcopal | 2 | 13 | 2 | 2 | 8 | 6 |
| 5. United Church | 0 | 0 | 11 | 11 | 7 | 6 |
| 6. Disciples | 1 | 6 | 10 | 10 | 19 | 15 |
| 7. Baptist | 2 | 13 | 11 | 11 | 5 | 4 |
| 8. Brethren | 1 | 6 | 2 | 2 | 3 | 2 |
| 9. Miscellaneous | 2 | 13 | 4 | 4 | 4 | 3 |
| 0. NA | 1 | 6 | 0 | 0 | 2 | 2 |
| 7. Education | | | | | | |
| 1. 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2. 1- 2 years | 1 | 6 | 0 | 0 | 1 | 1 |
| 3. 3- 4 years | 0 | 0 | 1 | 1 | 0 | 0 |
| 4. 5- 6 years | 0 | 0 | 2 | 2 | 4 | 3 |
| 5. 7 years | 5 | 31 | 35 | 35 | 41 | 32 |
| 6. 8- 9 years | 4 | 25 | 46 | 46 | 56 | 45 |
| 7. 10 years and over | 6 | 38 | 15 | 15 | 22 | 18 |
| 8. NA | 0 | 0 | 1 | 1 | 1 | 1 |

* See TABLE A for full description of categories

TABLE C (Continued)

| | Low<br>6-15<br>(16) | | Medium<br>16-20<br>(100) | | High<br>21-30<br>(125) | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| 8. Pastoral Clinical Training | | | | | | |
| 1. 0 | 8 | 50 | 62 | 62 | 58 | 46 |
| 2. 1- 6 weeks | 2 | 13 | 14 | 14 | 24 | 19 |
| 3. 7-12 weeks | 3 | 19 | 4 | 4 | 13 | 10 |
| 4. 13-18 weeks | 1 | 6 | 8 | 8 | 7 | 6 |
| 5. 19-24 weeks | 0 | 0 | 0 | 0 | 6 | 4 |
| 6. 25-30 weeks | 0 | 0 | 1 | 1 | 2 | 2 |
| 7. 31 weeks and over | 0 | 0 | 5 | 5 | 10 | 8 |
| 8. NA | 2 | 13 | 6 | 6 | 5 | 4 |
| 10. Parish Ministry | | | | | | |
| 1. 0- 1 year | 0 | 0 | 0 | 0 | 2 | 2 |
| 2. 2- 5 years | 1 | 6 | 7 | 7 | 11 | 9 |
| 3. 6- 9 years | 1 | 6 | 13 | 13 | 23 | 18 |
| 4. 10-19 years | 3 | 19 | 29 | 29 | 39 | 31 |
| 5. 20-29 years | 3 | 19 | 23 | 23 | 23 | 18 |
| 6. 30 years and over | 3 | 19 | 20 | 20 | 19 | 15 |
| 7. NA | 5 | 31 | 8 | 8 | 8 | 6 |
| 13. Threatened Suicides in Total Ministry | | | | | | |
| 1. 0 | 3 | 19 | 7 | 7 | 14 | 11 |
| 2. 1- 2 | 1 | 6 | 16 | 16 | 6 | 4 |
| 3. 3- 4 | 1 | 6 | 13 | 13 | 23 | 18 |
| 4. 5- 7 | 2 | 13 | 13 | 13 | 17 | 14 |
| 5. 8-10 | 3 | 19 | 10 | 10 | 11 | 9 |
| 6. 11-13 | 0 | 0 | 4 | 4 | 8 | 6 |
| 7. 14-16 | 0 | 0 | 4 | 4 | 7 | 6 |
| 8. 17-19 | 0 | 0 | 1 | 1 | 1 | 1 |
| 9. 20 and over | 2 | 13 | 8 | 8 | 18 | 14 |
| 0. NA | 4 | 25 | 24 | 24 | 20 | 16 |
| 16. Attempted Suicides in Total Ministry | | | | | | |
| 1. 0 | 3 | 19 | 25 | 25 | 32 | 26 |
| 2. 1- 2 | 3 | 19 | 28 | 28 | 30 | 24 |
| 3. 3- 4 | 2 | 13 | 14 | 14 | 27 | 22 |
| 4. 5- 7 | 3 | 19 | 7 | 7 | 8 | 6 |
| 5. 8-10 | 0 | 0 | 1 | 1 | 5 | 4 |
| 6. 11 and over | 0 | 0 | 2 | 2 | 2 | 2 |
| 7. NA | 5 | 31 | 23 | 23 | 21 | 16 |

TABLE C (Continued)

| | Low<br>6-15<br>(16) | | Medium<br>16-20<br>(100) | | High<br>21-30<br>(125) | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| 19. Committed Suicides in Total Ministry | | | | | | |
| 1. 0 | 10 | 63 | 56 | 56 | 65 | 52 |
| 2. 1- 2 | 3 | 19 | 21 | 21 | 31 | 25 |
| 3. 3- 4 | 0 | 0 | 5 | 5 | 6 | 4 |
| 4. 5- 7 | 0 | 0 | 1 | 1 | 4 | 3 |
| 5. 8-10 | 0 | 0 | 0 | 0 | 1 | 1 |
| 6. 11 and over | 0 | 0 | 0 | 0 | 0 | 0 |
| 7. NA | 3 | 19 | 17 | 17 | 18 | 14 |
| 22. Funerals in Total Ministry | | | | | | |
| 1. 0 | 6 | 38 | 23 | 23 | 34 | 27 |
| 2. 1- 2 | 3 | 19 | 29 | 29 | 22 | 18 |
| 3. 3- 4 | 1 | 6 | 12 | 12 | 13 | 10 |
| 4. 5- 7 | 2 | 13 | 8 | 8 | 20 | 16 |
| 5. 8-10 | 0 | 0 | 1 | 1 | 8 | 6 |
| 6. 11 and over | 0 | 0 | 5 | 5 | 9 | 7 |
| 7. NA | 4 | 25 | 22 | 22 | 19 | 15 |
| 25. Families of Suicides in Total Ministry | | | | | | |
| 1. 0 | 8 | 50 | 26 | 26 | 39 | 31 |
| 2. 1- 2 | 1 | 6 | 25 | 25 | 23 | 18 |
| 3. 3- 4 | 2 | 13 | 11 | 11 | 7 | 6 |
| 4. 5- 7 | 1 | 6 | 8 | 8 | 13 | 10 |
| 5. 8-10 | 0 | 0 | 2 | 2 | 3 | 2 |
| 6. 11 and over | 0 | 0 | 4 | 4 | 10 | 8 |
| 7. NA | 4 | 25 | 24 | 24 | 30 | 24 |
| 26. Referral | | | | | | |
| 1. Yes, outside church | 3 | 19 | 26 | 26 | 40 | 32 |
| 2. Yes, within church | 0 | 0 | 4 | 4 | 5 | 4 |
| 3. Both | 4 | 25 | 26 | 26 | 36 | 29 |
| 4. No | 3 | 19 | 22 | 22 | 23 | 18 |
| 5. NA | 6 | 38 | 22 | 22 | 21 | 16 |
| 43. Aquinas | | | | | | |
| 1. Agree on all | 12 | 75 | 65 | 65 | 5 | 4 |
| 2. Agree on two | 3 | 19 | 20 | 20 | 18 | 14 |
| 3. Agree on one | 1 | 6 | 14 | 14 | 23 | 18 |
| 4. Agree on none | 0 | 0 | 1 | 1 | 79 | 63 |
| 5. NA | 0 | 0 | 0 | 0 | 18 | 14 |

In brief, the average Protestant minister in the statistical study is a middle aged person with fifteen years of parish experience and eight years of formal education. His theological position on suicide may be considered moderate. He does have some reservations about accepting Aquinas' theology on suicide but views suicide from an existential or mental-illness perspective. The Protestant clergyman considers situational factors in suicide and believes in the full burial rites of all suicidal persons. He is somewhat dissatisfied with Aquinas, but he is also searching for other modes of meaningful expression to construct a theology of suicide.

## III. CONTEMPORARY PROTESTANT THEOLOGICAL ETHICS

Along with the contributions of Bonhoeffer and Barth as well as the statistical survey of parish ministers, current ethical trends must also be considered in the construction of a theology on suicide. There has been no application of contemporary Protestant theological ethics to the problem of suicide on the American scene. The purpose of this section is to present the essential methodology of four representatives in the contemporary ethical discussion. Issues raised by these new methodological approaches will supplement the existing theological contributions on suicide.

### Lehmann: Contextual Koinonia Ethics

Paul Lehmann formulates Christian ethics around the question, "What am I, as a believer in Jesus Christ and as a member of his church, to do?"[18] As such, the definitive question of ethics is not imperative

(What ought I) indicative (What am I). Lehmann stresses the "amness" of the environment-decision rather than to the "ought-ness" of rules-decision. In other words, his main concern is for an ethical analysis of the real situation.[19]

However, there are several presuppositions involved in Lehmann's contextual ethics. First, the contextual character of Christian ethics is derived from the ethical reality and significance of the Christian Koinonia.[20] The church is the koinonia-fellowship of Christ's presence in the world. Each individual in the fellowship of Christ's body functions in relation to the whole of the koinonia. From within the fellowship there is a running dialogue between prophetic-apostolic revelation and the illumination of the fellowship through the Holy Spirit. Lehmann emphasizes the orientation of Christian ethics toward revelation and not toward morality at this point.[21] But there is also openness to and for one another within the context of the concrete reality of the church. Maturity is the integrity through interrelatedness which makes it possible for each individual to be himself in a community. Thus, Christian ethics speaks from the context of this koinonia which gives a framework of meaning and a pattern of action in the concrete ethical situation.[22]

Second, from the context of the koinonia, the question is posed:

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[18] Paul L. Lehmann, _Ethics in a Christian Context_ (New York: Harper and Row, 1963), p. 25.

[19] _Ibid_., p. 347.

[20] _Ibid_., p. 15.

[21] _Ibid_., pp. 45, 49.

[22] _Ibid_., pp. 54, 55, 58, 62, 130, 131.

what is God doing in the world to make human life truly human?; or what are the activity and purposes of God in the world from which behavior can be shaped and guided? Only then can one know the will of God which arises from the situation.[23] For Lehmann, theonomous conscience is the focal point for man's obedient response to the activity of God in the world. Implicit in the theonomous conscience is the knowledge of good and evil. Moreover, theonomous conscience is sensitive to the humanizing aims and purposes of God in the changing human situation. Rather than a set of ethical rules Lehmann appeals to theonomous conscience which is the bond between the activity of God in the world and man's ethical behavior. In this sense, the role of theonomous conscience is crucial for the ethical orientation of the Christian believer.[24]

However, what is the application of contextual koinonia ethics to the behavior of non-Christians who do not acknowledge the koinonia as their point of departure? Do we have a double ethical standard: one for Christians and another for non-Christians? Lehmann's answer is that koinonia-ethic describes and analyzes the context of the concrete human reality.[25] The common predicament for both believer and unbeliever is the falsification or the fulfillment of the authentic humanity of every human being. Lehmann even refers to unbelievers as "the other sheep of the Holy Spirit of God." Lehmann appeals to general revelation in this instance. He points out that Luther believed in the hidden character of the divine activity where unbelievers can bring forth fruits worthy of repentance without being baptized members of the community. He cites Calvin's belief in the general power of the Spirit where the same Spirit which informs the koinonia also shapes the new humanity in the world. One who has never been baptized in the koinonia may behave like the Lord's anointed.[26]

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[23] Ibid., p. 15.

[24] Ibid., pp. 350, 358, 359, 360.

[25] Ibid., p. 152.

Application to Suicide. Although Lehmann nowhere applies his ethical methodology to the problem of suicide, he has expressed his theological views on the matter in personal correspondence. Observing suicide as a crucial "ethical exception," he wrote:

> This means at least that suicide cannot be condemned out of hand and cannot be read as a ground for excluding a person who takes his own life from the fellowship of the church and the means of grace. In this respect the tradition of Christian ethics is in my judgment seriously in default. At the same time, suicide is in my view a deep symptom of the alienation of man from God and a sign of the fact that we all continually stand in need of divine mercy and grace.[27]

With this statement as a reference point, we will extend Lehmann's comments to include ethical methodology and its possible application to the problem of suicide.

Since Lehmann's ethics are decisions according to an ethical analysis of the situation, he would be quite critical of traditional and legal condemnations and burial exclusion of suicidal persons. His emphasis would be on a descriptive analysis of the suicidal situation via koinonia contextual ethics. For Lehmann, suicide is "a deep symptom of the alienation of man from God."[28] As such, the suicide cannot ask, What am I, as a believer in Jesus Christ and as a member of his church, to do? He may be unable to pose the question due to his emotional condition. The suicidal person may be a believer in Jesus Christ but may feel isolated from the koinonia-fellowship. For him the koinonia may be a meaningless place of action for the concrete ethical situation. Certainly the suicide does not know the meaning of maturity: the integrity through interrelatedness of the koinonia. His conscience can not be sensitive to the freedom of God in the world, nor can he be free in obedience. Rather, the suicide is bound toward a course of disobedience and has become insensitive to the freedom of God.

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[26] Ibid., pp. 157, 158.

[27] Paul L. Lehmann, personal correspondence to Doman Lum, (April 28, 1966), pp. 1-2.

Finally we could ask: what is God doing in the world to make human life truly human for the suicide or what are the activity and purposes of God in the world to evaluate the suicidal behavior of an individual? Certainly God's activity in the world for the suicide is on the side of divine grace and mercy. The proclamation of His gospel is that God has set man free from his tendency to destroy himself. The koinonia-fellowship is a source of interrelatedness wherein a suicidal person can experience maturity as a part of the whole. Only then can the suicide gain enough strength to assert his good "am-ness." Lehmann might ask: what is meaningful dialogue between revelation and the koinonia-fellowship regarding suicide?; in what sense is theonomous conscience operational for the suicidal person, especially in ambiguous situations? Certainly Lehmann's ethical methodology departs from traditional morality and could give the problem of suicide contextual

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[28] Ibid.

consideration.

## Fletcher: Situation Ethics

Joseph Fletcher believes that Christian ethics is applicable to any situation where sensitive decision-making is involved whether the circumstances be Christian or non-Christian.[29] His situationalism aims at contexual appropriateness. Principles (maxims of "good" or "right") are treated by Fletcher as illuminators of the problem and may be set aside or compromised if the situation demands otherwise. His term for the role of principles, "principled relativism," is contingent on love in the situation. Situation ethics is tailored toward the fitting and accepts only one command, to love God in the neighbor, as the source of all revelatory norms. Only love is intrinsically good and objective in the situation. The situationalist holds that the most loving thing in the situation is the right and good thing. Conscience as a function of prospective decision-making is subordinate to Fletcher's criteria of love.[30]

Since love is the primary norm in Fletcher's ethics, considerable attention is given to the nature of love, especially in relation to justice and as a tool for decision-making. The ethical norm of love has multiple meaning for Fletcher. Love replaces law and is good will at work in partnership with reason. In contrast to the emotional nature of erotic and philic love, Christian love is will and disposition as well as attitude. In the end, love, unlike law, sets no calculated limits on obligation. It seeks the most good possible in every situation. In this sense, love maximizes the obligation of maturity and responsibility as well as the life of freedom by grace.[31] Regarding love and justice as synonymous concepts, Fletcher states: to be loving is to be just and to be just is to be loving. Justice is love calculating its duties, obligations, opportunities and resources and is redefined to promote the best interests of love.[32] Fletcher also relates the ethics of love in relation to the neighbor.[33] In this regard, love is benevolence and good will. It seeks the good of anybody and everybody. He says: "For to love God and the neighbor is to love one's self in the right way; to love one's neighbor is to respond to God's love in the right way; to love one's self in the right way is to love God and one's neighbor."[34]

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[29] Joseph Fletcher, Situation Ethics (Philadelphia: Westminster Press, 1966), p. 14.

[30] Ibid., pp. 26-65.

In respect to decision-making, love always serves a good end in the situation. Fletcher presents four factors for decision-making: 1) the end (what is wanted? what is the object sought? what result is aimed at?); 2) the means (what method should be employed to bring about the end sought?); 3) the motive (what is the drive or "wanting" dynamic behind the act?); and 4) the forseeable consequences (what are the immediate and remote effects directly and indirectly?). However, the one goal and purpose is love.[35] In the end, Fletcher's situation ethics may be summarized by the following statement:

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[31] Ibid., pp. 69-85.

[32] Ibid., pp. 87-102.

[33] Ibid., pp. 103-119.

[34] Ibid., p. 114.

[35] Ibid., pp. 127-129.

> Love, in the imperative mood of neighbor-concern, examining the relative facts of the situation in the indicative mood, discovers what it is obliged to do, what it should do, in the normative mood. What is, in the light of what love demands, shows what ought to be.[36]

Application to Suicide. Since Fletcher is distressed at any sign of legalism and favors principled relativism, his position on suicide would be based on the determining situation. In certain cases suicide is the most loving act in a given situation. For example, elsewhere Fletcher deals with the question of suicide in relation to the problem of voluntary euthanasia. His concern is mercy-killing for terminal patients who are undergoing extreme suffering. Fletcher admits:

> As far as voluntary euthanasia goes, it is impossible to separate it from suicide as a moral category; it is, indeed, a form of suicide. In a very proper sense, the case for medical euthanasia depends upon the case for the righteousness of suicide, given the necessary circumstances. And the justification of its administration by an attending physician is therefore depend upon it too, under the time-honored rule that what one may lawfully do another may help him to do.[37]

Furthermore, Fletcher points to the fifth beatitude, "Blessed are the merciful," as a divine provision for certain cases of mercy killing. He observes that the mere fact of being alive is not as important as the terms of living. In the case of illness, incurable pain destroys self-possession and disintegrates personality.[38]

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[36] Ibid., p. 151.

[37] Joseph Fletcher, Morals and Medicine (Boston: Beacon Press, 1960), p. 176.

Thus, love in the form of sensitive decision-making may require suicide in certain situations. However, contextual appropriateness may conclude that suicide is not the most loving thing. An indiscrimate act of self-destruction may not foster goodwill in partnership with reason. Suicide may appear irrational. It may not be the good in the situation nor fulfill the obligation of maturity and responsibility. Fletcher would certainly evaluate the specific act of suicide in a given situation with his criteria of decision-making (the end, the means, the motive, the foreseeable consequences). Love prevails as the decisive factor in a decision for or against suicide. Fletcher would neither condemn all instances of suicide nor would be advocate the use of suicide for all crisis situations. He would be open to the possibility that suicide might best express his ethic of love in certain situations.

## Ramsey: In-Principled Love Ethics

Paul Ramsey's main contribution to the contemporary discussion in Christian ethics has been a responsible consideration of love-embodying rules of action. He states:

> The rule issue is whether there are any agape-or koinonia-embodying rules; and, if there are, what these rules may be. Theologians today are simply deceiving themselves and playing tricks with their readers when they pit the freedom and ultimacy of agape (or covenant-obedience, or koinonia, or community, or any other primary theological or ethical concept) against rules, without asking whether agape can and may or must work through rules and embody itself in certain principles which are regulative or the

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[38] Ibid., pp. 187, 190, 191.

guidance of practice.[39]

However, Ramsey does not exclude the need for a situational side in Christian ethics. A proper understanding of the moral life includes a determination of the most love-embodying rules of action as well as a clarification of the facts of the situation for the Christian. In this sense, Ramsey speaks about a rule-koinonia ethic and an act-koinonia ethic.[40] He is even open to the possibility that there may be rules, principles, or percepts whose source is man's natural competence to make moral judgments.[41] By this admission, Ramsey realizes that there may be situations which are not covered by rules *per se*. In these instances, individual judgment in light of the contextual situation may be exercised to make a decision. But Ramsey insists that Christian ethics must consider the means for right conduct - not merely the concern for good and evil consequences - and must determine the requirements of love. As James M. Gustafson declares:

> Methodologically it is not the situation alone that determines, but the operating principles that determine what one ought to do in the situation. Substantively, when love is worked out in the form of summary rules we find out what it restricts as well as what it permits. For Ramsey, too, persons act in situations, and responsibility is theirs. But they may do the wrong things, as well as what is right.[42]

Having established his case for rule-principles, Ramsey's basic ethical orientation centers around his concept of obedient love. Christian ethics originate from two sources of Christian love: 1) God's righteousness and love and 2) the reign of this righteousness in the kingdom of God. In obedient love a Christian is bound to the covenant of righteousness of justice under the reign of God. A rule-ethic emerges from obedience to the covenant, but faith also expresses itself through love of neighbor. Thus, internal self-regulations are defined in terms of the needs of neighbors.[43] The Christian is bound even closer to the needs of others. The choices of an individual are determined by his duties to his neighbor for one's own self-centeredness is sin and is opposite to obedient love.[44]

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[39] Paul Ramsey, *Deed and Rules in Christian Ethics* (Edinburgh: Oliver and Boyd, 1965), p. 4.

[40] *Ibid*., pp. 3-5.

[41] *Ibid*., pp. 109-110.

[42] James M. Gustafson, "Christian Ethics," in *Religion* (Englewood

Application to Suicide. Although Ramsey nowhere explains his ethical position on suicide, his methodology leads us to ask the following questions: what are the most love-embodying rules of action for the ethical problem of suicide? what are the particular facts of the suicidal situation? what are the necessary means for right conduct in view of possible suicidal death? can love permit or forbid a specific suicide? what does the covenant for obedient love say concerning suicide? and what are the motives for suicide-altruistic or selfish - and the consequences of suicide for the neighbor?

Perhaps the issue of suicide should be evaluated in terms of right conduct. Ramsey declares:

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Cliffs, N. J.: Prentice-Hall, 1965), p. 287.

[43] Paul Ramsey, Basic Christian Ethics (New York: Charles Scribner's sons, 1950), pp. 1, 2, 78, 89, 219, 388.

[44] James M. Gustafson, "How Does Love Reign?", Christian Century (May 18, 1966), pp. 654, 655.

> ...love posits or takes form in principles of right conduct which express the difference it discerns between permitted and prohibited action, and these are not wholly derived from reflection upon the consequences.[45]

As such, love in the form of principles of right conduct weighs the alternative actions which do not violate the love-commandment as well as the means and the good-and-evil-effects of actions.[46] It is my feeling that Ramsey would generally be against suicide. Self-destructive suicide would violate the principle of right conduct, would be an expression of selfish disobedience, and would have an evil effect upon the neighbor. In personal correspondence he does make a distinction between ethical justification and ethical excusability regarding suicide. Ramsey stresses that Protestants have wrongly understood suicide on the basis of situational ethical justification. Ramsey's own position would be to oppose suicide before the fact, but pronounce the forgiveness of God (ethical excusability) after the completion of the suicide rather than make a case for particular suicides (ethical justification).[47]

### Niebuhr: Ethics of Responsibility

Whereas theology is concerned with the highest good and deontology concentrates on the right (no matter what may happen to our good), H. Richard Niebuhr's ethics of responsibility centers on the fitting action appropriate to the total interaction as response and as anticipation of further response. Such an emphasis on responsibility is alone conducive to the good and alone is right.[48] There are several elements in Niebuhr's concept of responsibility. In terms of response, all moral action is response to meaningful action in awareness by the individual. Furthermore, action-response is based upon the interpretation to the questions: what is going on and what is being done to me? However, our actions as reactions to interpreted actions have a sense of accountability. They are made in anticipation of reactions to our reactions. As such, there is a social solidarity to our actions. This implies a response to action upon us in a continuing interaction among beings forming a society.[49]

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[45] Paul Ramsey, War and The Christian Conscience (Durham: Duke University Press, 1961), p. 4.

[46] Ibid., pp. 4. 8, 9.

[47] Paul Ramsey, personal correspondence to Doman Lum (May 10, 1966).

For example, responsibility in society is to acknowledge one's existence in relation to other selves in a pattern of interaction. As Niebuhr says:

> I can respond to the action of the other, or anticipate his reaction to my action, only as I interpret his movements directed toward me. I respond to his action not as isolated event but as action in a context, as part of a larger pattern.[50]

However, response between the self and others occurs in the large world of events and agencies. Response becomes responsibility to a third reality which may be something personal or reference to a transcendent element. Thus, Niebuhr introduces the notion of universal responsibility which is a life of responses to actions taking place in a universe.

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[48] H. Richard Niebuhr, The Responsible Self (New York: Harper and Row, 1963), pp. 60, 61.

[49] Ibid., pp. 61-68.

[50] Ibid., p. 77.

Niebuhr's concept of responsibility is summarized in the phrases: "God is acting in all actions upon you. So respond to all actions upon you as to respond to his action."[51] Ethical responsibility is response of man to the God who acts upon man. Perhaps his concept of responsibility in sin and salvation is a pertinent example of responsibility as response. Niebuhr analyzes the self as responsive and responsible in regards to sin and salvation. For Niebuhr, internal conflict and division is the human condition of the self. One is irresponsible as a self when one is irresponsible to the One beyond the many (God), even though one is responsive and responsible to the many (man-to-man). Conflict within the self even occurs when one turns from the many systems of actions to one's self. Even the One is regarded as the enemy. Niebuhr states:

> In the contradictoriness of our existence we do respond to One action present in all actions upon us. We do interpret all things that happen to us as occurring with One realm, as related to One intention so far as this life of selfhood and community is concerned. But the One beyond the many is the enemy, the creative source whence comes destruction.[52]

Salvation delivers the self from its deep distrust of the One. Through the life, death, and resurrection of Jesus Christ, the self is led to rependence and to the reinterpretation of life and death. He points out:

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[51] *Ibid.*, p. 126.

[52] *Ibid.*, pp. 175, 176.

> But now for Christians Jesus Christ appears not only as the symbol of an ethos in which the ultimate response to the incrutable power in all things is one of trust. He is also the one who accomplishes in them this strange miracle, that he makes them suspicious of their deep suspicion of the Determiner of Destiny. He turns their reasoning around so that they do not begin with the premise of God's indifference but of his affirmation of the creature, so that the Gestalt which they bring to their experiences of suffering as well as of joy, of death as well as of life, is the Gestalt, the symbolic form, of grace.[53]

To be responsible is to do what fits into divine action. Considering our response to action upon us, the ethics of responsibility poses the questions: 1) What is happening? 2) What is the fitting response to what is happening? 3) To whom or to what am I responsible? and 4) In what community of interaction am I myself?[54] Responsible action is guided by an examination of the situation in terms of these issues.

Application to Suicide. Niebuhr's ethics of responsibility would ask whether suicide is fitting action appropriate to the total interaction as response and as anticipation of further response. What is happening in suicide? What is the fitting response to the suicidal act? Does suicide manifest a sense of responsibility to something? How does suicide affect the social community of which the suicide person is a part?

There is evidence against suicide implied in Niebuhr's ethical structure of responsibility. Suicide has a destructive effect because the self is in responsive relations to others in a system of interaction. Responsibility is not exercised toward others or toward the universe. Concerning suicide Niebuhr remarks about one existence:

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[53] Ibid., pp. 175, 176.

[54] Ibid., pp. 67, 68.

> I can destroy the life of my body. Can I destroy myself? This remains the haunting question of the literature of suicide and of all the lonely debates of men to whom existence is a burden. Whether they shall wake up again, either here in this life or there in some other mode of being, is beyond their control. We can choose among many alternatives; but the power to choose self-existence or self-control, not self-creation; they can commit bio-cide; whether they can commit suicide, self-destruction remains a question.[55]

His analysis of sin certainly speaks to the condition of the suicide: internal conflict and division, distrust of God, movement toward death. However, he describes salvation in meaningful terms for the suicide. It is a reinterpretation process in life-giving action. Trust is fostered once again. God affirms man as his creature.

However, the problem of suicide is related to responsibility in terms of response. Granted that responsibility is human response to the action of God upon man. The application of this definition implies that the suicide does not respond in trust to God. Suicide is not the fitting response to the action of God upon man and is therefore contrary to the ethics of responsibility.

## IV. CRITIQUE

Contemporary Protestant theological ethics asserts that suicide is self-murder and is therefore a sin against the 'preservation of life' principle which is given by God. Only God is sovereign over life. There is consideration of the freedom and responsibility of man, altruistic suicide, situational factors, the existential interpretation of man, and the mercy and grace of God. As such, contemporary theological discussions on suicide proclaim the positive nature of the gospel rather than a series of negative arguments against suicide. Our statistical study on the theological views of Protestant clergymen concerning suicide reflects a moderate outlook. Self-destruction is understood in terms of existential despair and mental illness.

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[55] Ibid., pp. 114, 115.

While an ethical analysis of the situation is crucial to the problem of suicide, caution must be exercised against an indiscriminate use of contextual ethics. For example, Joseph Fletcher advocates "principled relativism" where principles may be compromised when love alone is not exercised in the situation. In light of the serious nature of the suicide problem, Fletcher's unqualified use of love substituted for ethical rules may be sheer brinkmanship in a life-or-death matter. In certain circumstances love does not include rules, according to Fletcher. Certainly the suicidal person himself may be in no condition to discern what love demands in the situation which is the sole ethical criteria for Fletcher. Therefore, an adequate theology on suicide requires ethical rules based on secondary situational considerations.

In distinction to Fletcher, Paul Ramsey has insisted that rules can be expressed through love. Again, a theological formulation on suicide must insist upon responsible love-embodying ethical rules which stress right conduct.

However, it is our contention that ethical rules as well as the ethical context must be incorporated in a contemporary theological discussion on suicide. Perhaps H. Richard Niebuhr's ethics of responsibility may help to resolve the debate on contextual and rules ethics. Niebuhr does ask situational questions: What is happening? What is the fitting response to what is happening? But his system leaves room for ethical rules in response to the action of God. Thus, Niebuhr's understanding of ethics could be adopted and later modified in any combined effort to relate situational and rules ethics to the problem of suicide.

This brief critique does not intend to shape a theology on suicide for contemporary man. It has merely tried to connect the broad ideas of this chapter into a concise estimation of necessary ingredients for a Revised Model concerning suicide. After a consideration of contemporary changes in pastoral counseling regarding suicide, an integration between theological ethics and pastoral counseling will be attempted toward an adequate theological and psychological model for the church.

# CHAPTER IV

# CONTEMPORARY CHANGES: PROTESTANT PASTORAL COUNSELING

Today the church must not only rethink its theological position on suicide; it must also keep abreast of the latest clinical-psychological trends and findings in suicide prevention. Suicidal persons look to clergymen not only to assess the morality of their actions, but also to help them therapeutically in their struggles for life itself. This chapter sketches the contemporary changes occurring in Protestant pastoral counseling and its application to suicide prevention, specifically the growth of the pastoral counseling movement, statistical aspects of the study involving pastoral counseling experiences with suicidal persons, case studies of individual clergymen and their accounts of suicides in the ministry, and an outline of psychological insights which may further aid pastors in their care of suicidal persons.

## I. CONTEMPORARY PASTORAL COUNSELING

The modern pastoral counseling movement in the United States began with Anton T. Boisen in the early 1930's. In his autobiography, Boisen recalled that his mental condition reached an acute psychotic stage after a few years in parish work. He was subsequently committed to a mental institution, which proved to be a learning experience for him. Analyzing his own condition, Boisen insisted that psychoses had a purposeful etiology. He said: "They are due to deep-seated conflict between great subconscious forces and the *cure is to be found not in* the suppression of the symptoms but in the solution of the conflict."[1]

After his release from the hospital and further studies in psychology of religion and mental illness, Boisen initiated a chaplain's training program, at Worchester State Hospital in Massachusetts, with theological seminary students. He was later appointed to the staff of Chicago Theological Seminary where he established a program of pastoral counseling with clinical training at nearby Elgin State Hospital in Illinois. In his classroom lectures Boisen sought to make sense out of the abnormal conditions. He said:

> The conclusion follows that certain types of mental disorder and certain types of religious experience are alike attempts at reorganization. The difference lies in the outcome. Where the attempt is successful and some degree of victory is won, it is commonly recognized as religious experience. Where it is unsuccessful or indeterminate, it is commonly spoken of as "insanity."[2]

Boisen took the fear and stigma out of mental illness when he interpreted the period of disturbance as the attempt of the better self to gain control.[3] In short, Anton Boisen developed a religious psychotherapy based on the positive meaning behind mental disorder. Subsequently pastoral counseling has become a recognized discipline in the theological seminary.

After three decades of hospital pastoral clinical training in the United States, thousands of clergymen have been trained through joint programs sponsored by theological schools and special training agencies.[4] One estimate is that during the summer of 1959 some six-hundred students for the Protestant ministry took some type of clinical pastoral work in hospitals and institutions accredited by four major denominational and interdenominational agencies.[5] Advanced programs in pastoral counseling and clinical training on the master's and doctoral levels are found in the curriculum of major Protestant theological seminaries in the United States. As a result, some clergymen have specialized in pastoral counseling and have become ministers of counseling in multiple-staff churches or have gone into private practice as pastoral counselors. By 1964 there were at least one-hundred and sixty-four pastoral counseling centers in twenty-nine states and the District of Columbia. Eighty-four per cent of these centers were not in existence in 1953 and over half of them were started between 1959 and 1964. There were six hundred and eight counselors, representing fifteen professions, serving in one-hundred and thirty-five centers. Three-fourths of these counselors are clergymen while one-fifth (21.9%) are from three professions: psychiatrists, social workers, and clinical and counseling psychologists. The vast majority of the counselors in church-related centers give part-time service.[6] In 1964 the American

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[1] Anton T. Boisen, Out of the Depths (New York: Harper and Brothers, 1960), p. 103.

[2] Anton T. Boisen, The Exploration of the Inner World (New York: Harper and Brothers, 1936), IX (forward to first edition).

[3] Ibid., pp. 81, 82.

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[4] Seward Hiltner and Jesse H. Ziegler, "Clinical Pastoral Education and The Theological Schools," Journal of Pastoral Care, XV, 3 (Fall, 1961), p. 129.

[5] Ernest E. Bruder, "Present Emphases and Future trends in Clinical Training for Pastoral Counseling," Pastoral Psychology, XI, 103 (April, 1960), p. 33.

[6] Berkley C. Hathorne, A Critical Analysis of Protestant Church Counseling Centers (Washington: Division of Alcohol Problems and

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Association of Pastoral Counselors was formed by denominational representatives, seminary professors, pastoral counselors and other interested persons in religion and psychology. Its purposes were to set standards and accredit qualified pastoral counselors and pastoral counseling centers.

The challenge of pastoral counseling has been to make significant contributions in unexplored areas common to religion and mental health. As Paul W. Pruyser observes:

> Here is a pluralistic society with an extremely diversified church life, in which members of congregations demand their churches and their pastors to assume new dynamic roles without abolishing the traditional ones; to be in the forefront of social movements; to be practically helpful in all the important areas of human welfare; to be expertly relevant to the many forms of human suffering.[7]

It is the conviction of this study that one of the areas for exploration is the pastoral care of suicidal persons. Do clergymen have pastoral contact with suicidal persons? What happens in pastoral counseling situations with suicides? What are the unique therapeutic contributions that clergymen can make in suicide cases? Are clergymen trained to counsel suicidal persons? If not, what psychological acumen should clergymen have as they counsel suicides? One of our purposes is to answer these questions and to point out the direction that should be taken in the pastoral care of suicidal persons.

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General Welfare, Board of Christian Social Concerns, (The Methodist Church, 1964), pp. 72, 73.

[7] Paul W. Pruyser, "Forward," in Heije Faber, Pastoral Care and Clinical Training in America (Arnhern: Van Loghum Slaterus, 1961), p. 7.

## II. STATISTICAL STUDY AND CASE STUDIES

### Statistical Study

The statistical study on the pastoral counseling experiences of the three-hundred and twenty-three Protestant clergymen revealed that during the year 1965 there was minimal contact with suicidal persons. (See Table A.) Most of these ministers reported some counseling with persons who threatened suicide (no persons 28%, 1-2 persons 37%, 3-4 persons 12%). However, over half of them claimed no counseling experience with attempted and committed suicides as well as pastoral care of suicide funerals and families of suicides. (No attempted suicides 52%, no committed suicides 73%, no funerals of suicides 50%, no pastoral care of families of suicides 49%.) The next highest group reported about one or two counseling contacts with attempted and committed suicides and pastoral care of suicide funerals and families of suicides (1-2 attempted suicides 29%, 1-2 committed suicides 10%, funerals of suicides 32%, pastoral care to families of suicides 22%). The rest of the categories showed nothing of significant nature.

However, over their total ministry there was a broader distribution of experience with threatened and attempted suicides as well as funerals of suicides and contact with families of suicides. Ministers reported that they had counseled with one to ten threatened suicides (no persons 10%, 1-2 persons 11%, 3-4 persons 14%, 5-7 persons 13%, 8-10 persons 11%). However, there was a decrease in other categories. For example, the parish minister averaged about one to four attempted suicide counselees during his total ministry (no persons 24%, 1-2 persons 25%, 3-4 persons 17%) while contact with funerals of suicides numbered roughly one to seven and with families of suicides about one to two during his total ministry (attempted suicide no persons 24%, 1-2 persons 25%, 3-4 persons 17%; funerals of suicide no persons 25%, 1-2 persons 19%, 3-4 persons 9%, 5-7 persons 13%; pastoral care to families of suicides no families 28%, 1-2 families 17%). Half of the ministers in their total parish ministry had no counseling contact with a person who eventually committed suicide (no persons 52%, 1-2 persons 24%).

These trends indicate that ministers have moderate contact with threatened and/or attempted suicides but slight counseling experience with committed suicides. One may speculate that either 1) ministers effectively prevent suicide and are able to save lives through counseling and/or by referral to other medical professionals or 2) that persons with suicidal tendencies do not approach ministers but seek help via other resource agencies. Suicidal persons may not approach ministers because the church has traditionally judged the act of suicide as a sin. Further research should determine the reasons for the ministers based on these statistics.

Apart from the general survey of pastoral counseling experience with suicidal persons, pastoral clinical training is an important factor in the counseling of suicides. (See Table D on Clinical Training.) Ministers were divided into three groups: no training (low), one to twelve weeks of training (medium), and thirteen weeks or more of training (high). The high group showed slightly more education than the other two groups (high group 7 years 23%, 8-9 years 50%, 10 years and over 25%; medium group 7 years 30%, 8-9 years 51%, 10 years and over 13%; low group 7 years 39%, 8-9 years 38%, 10 years and over 16%).

Concerning years in the parish ministry, the high group seemed to cluster around ten to twenty-nine years (10-19 years 31%, 20-29 years 27%) while the low group included from ten to thirty years and over (10-19 years 33%, 20-29 years 21%, 30 years and over 21%). The medium group had less years in the parish (6-9 years 20%, 10-19 years 24%, 20-29 years 20%). In Table E dealing with age and clinical pastoral training, the young group (ages 20-39) tended to have more training than the older group (ages 60 and over) (young no training 48%, 1-6 weeks 21%, 7-12 weeks 12%; old no training 70%, 1-6 weeks 6%, 7-12 weeks 6%). The middle group (ages 40-59) modulated between the two others (middle no training 54%, 1-6 weeks 15%, 7-12 weeks 6%).

Generally speaking, more pastoral clinical training did not mean greater frequency of experience with suicide. Those ministers without any clinical training reported a 10%-16% variation in threatened suicides from no persons to ten persons. The medium group recorded 20% counseling experience with five to seven threatened suicides. The high group showed that 25% had twenty or more experiences with threatened suicides but there were also 27% no answers for the same group. Less frequent contacts with attempted and committed suicides as well as funerals for suicides and pastoral care to families of suicides revealed the same pattern previously mentioned concerning over-all figures. (See Table D). The highly trained group tended to use referral outside the church more than the group without training (referral outside the church high group 40%, medium group 33%, low group 26%). The group without training (21%) and the medium trained group (18%) gave some indication against referral compared to the group with considerable training (8%). This may mean that some ministers felt that they themselves were able to help suicidal persons without further referral. However, in the question dealing with certainty in counseling with suicidal persons, no substantial trends can be determined to correlate training with certainty in counseling.

## TABLE D*

## HOW PROTESTANT MINISTERS WITH DIFFERENT LENGTHS OF CLINICAL TRAINING VARY ON SELECTED SUICIDE EXPERIENCE

| | Clinical Training | | | | | | Question 8 | |
|---|---|---|---|---|---|---|---|---|
| | Low<br>0 wks<br>(173) | | Medium<br>1-12 wks<br>(79) | | High<br>13-31 wks<br>(52) | | NA<br><br>(19) | |
| IBM Card Columns | No. | % | No. | % | No. | % | No. | % |
| 7. Education | | | | | | | | |
| 1. 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| 2. 1- 2 years | 2 | 1 | 0 | 0 | 0 | 0 | | |
| 3. 3- 4 years | 3 | 2 | 0 | 0 | 0 | 0 | | |
| 4. 5- 6 years | 6 | 4 | 4 | 5 | 1 | 2 | | |
| 5. 7 years | 67 | 39 | 24 | 30 | 12 | 23 | | |
| 6. 8- 9 years | 66 | 38 | 40 | 51 | 26 | 50 | | |
| 7. 10 years and over | 28 | 16 | 10 | 13 | 13 | 25 | | |
| 8. NA | 1 | 1 | 1 | 1 | 0 | 0 | | |
| 10. Parish Ministry | | | | | | | | |
| 1. 0- 1 year | 1 | 1 | 1 | 1 | 1 | 2 | | |
| 2. 2- 5 years | 8 | 5 | 2 | 3 | 3 | 6 | | |
| 3. 6- 9 years | 19 | 11 | 16 | 20 | 5 | 10 | | |
| 4. 10-19 years | 56 | 33 | 19 | 24 | 16 | 31 | | |
| 5. 20-29 years | 36 | 21 | 16 | 20 | 14 | 27 | | |
| 6. 30 years and over | 36 | 21 | 11 | 14 | 6 | 12 | | |
| 7. NA | 17 | 10 | 6 | 8 | 7 | 13 | | |
| 13. Threatened Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 21 | 13 | 3 | 4 | 5 | 10 | | |
| 2. 1- 2 | 22 | 13 | 8 | 10 | 1 | 2 | | |
| 3. 3- 4 | 28 | 16 | 11 | 14 | 4 | 8 | | |
| 4. 5- 7 | 17 | 10 | 15 | 20 | 6 | 12 | | |
| 5. 8-10 | 17 | 10 | 12 | 15 | 5 | 10 | | |
| 6. 11-13 | 8 | 5 | 4 | 5 | 3 | 6 | | |
| 7. 14-16 | 10 | 6 | 3 | 4 | 1 | 2 | | |
| 8. 17-19 | 2 | 1 | 1 | 1 | 1 | 2 | | |
| 9. 20 and over | 16 | 9 | 8 | 10 | 12 | 25 | | |
| 0. NA | | | | | | | | |

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* See TABLE A for full description of categories

TABLE D (Continued)

| | Low<br>0 wks<br>(173) | | Medium<br>1-12 wks<br>(79) | | High<br>13-31 wks<br>(52) | | NA<br><br>(19) | |
|---|---|---|---|---|---|---|---|---|
| IBM Card Columns | No. | % | No. | % | No. | % | No. | % |
| 16. Attempted Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 46 | 27 | 17 | 22 | 7 | 13 | | |
| 2. 1- 2 | 46 | 27 | 22 | 28 | 9 | 17 | | |
| 3. 3- 4 | 28 | 16 | 17 | 22 | 9 | 17 | | |
| 4. 5- 7 | 11 | 6 | 7 | 9 | 6 | 12 | | |
| 5. 8-10 | 3 | 2 | 0 | 0 | 5 | 10 | | |
| 6. 11 and over | 3 | 2 | 4 | 5 | 2 | 4 | | |
| 7. NA | 36 | 21 | 13 | 16 | 15 | 30 | | |
| 19. Committed Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 97 | 56 | 44 | 46 | 20 | 40 | | |
| 2. 1- 2 | 37 | 21 | 19 | 24 | 15 | 30 | | |
| 3. 3- 4 | 12 | 7 | 1 | 1 | 2 | 4 | | |
| 4. 5- 7 | 0 | 0 | 3 | 4 | 4 | 8 | | |
| 5. 8-10 | 0 | 0 | 0 | 0 | 1 | 2 | | |
| 6. 11 and over | 0 | 0 | 0 | 0 | 1 | 2 | | |
| 7. NA | 27 | 16 | 12 | 15 | 10 | 20 | | |
| 22. Funerals in Total Ministry | | | | | | | | |
| 1. 0 | 48 | 28 | 23 | 29 | 7 | 13 | | |
| 2. 1- 2 | 28 | 16 | 19 | 24 | 9 | 17 | | |
| 3. 3- 4 | 16 | 9 | 9 | 11 | 2 | 4 | | |
| 4. 5- 7 | 21 | 13 | 10 | 13 | 10 | 20 | | |
| 5. 8-10 | 9 | 5 | 0 | 0 | 4 | 8 | | |
| 6. 11 and over | 12 | 7 | 4 | 5 | 6 | 12 | | |
| 7. NA | 39 | 23 | 14 | 18 | 15 | 30 | | |
| 25. Families of Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 55 | 32 | 23 | 29 | 11 | 22 | | |
| 2. 1- 2 | 24 | 14 | 18 | 23 | 7 | 13 | | |
| 3. 3- 4 | 15 | 9 | 10 | 13 | 2 | 4 | | |
| 4. 5- 7 | 14 | 8 | 3 | 4 | 9 | 17 | | |
| 5. 8-10 | 4 | 2 | 0 | 0 | 2 | 4 | | |
| 6. 11 and over | 12 | 7 | 2 | 3 | 5 | 10 | | |
| 7. NA | 49 | 28 | 23 | 29 | 17 | 33 | | |

TABLE D (Continued)

| | Low<br>0 wks<br>(173) | | Medium<br>1-12 wks<br>(79) | | High<br>13-31 wks<br>(52) | | NA<br><br>(19) | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| 26. Referral | | | | | | | | |
| 1. Yes | 100 | 58 | 51 | 65 | 33 | 63 | | |
| 2. No | 42 | 24 | 21 | 27 | 10 | 20 | | |
| 3. NA | 31 | 18 | 7 | 9 | 10 | 20 | | |
| 28. Referral to LASPC | | | | | | | | |
| 1. Yes | 22 | 13 | 13 | 16 | 14 | 27 | | |
| 2. No | 70 | 40 | 36 | 46 | 17 | 33 | | |
| 3. NA | 35 | 20 | 10 | 13 | 11 | 22 | | |
| 4. No (on question 27) | 46 | 27 | 20 | 25 | 11 | 22 | | |
| 30. Certainty in Counseling Suicides | | | | | | | | |
| 1. Certain | 27 | 16 | 8 | 10 | 12 | 23 | | |
| 2. Somewhat certain | 59 | 34 | 39 | 50 | 16 | 31 | | |
| 3. Not certain at all | 44 | 25 | 21 | 27 | 9 | 17 | | |
| 4. NA | 43 | 25 | 10 | 13 | 15 | 30 | | |

## TABLE E*

## HOW PROTESTANT MINISTERS OF DIFFERENT AGE GROUPS VARY ON SELECTED VARIABLES IN SUICIDE COUNSELING EXPERIENCE

|  | Age |  |  |  |  |  | Question 5 |  |
|---|---|---|---|---|---|---|---|---|
|  | Young<br>20-39 yrs<br>(113) |  | Middle<br>40-59 yrs<br>(166) |  | Old<br>60 yrs-<br>(35) |  | NA<br><br>(9) |  |
| IBM Card Column | No. | % | No. | % | No. | % | No. | % |
| 6. Denomination |  |  |  |  |  |  |  |  |
| 1. Presbyterian | 22 | 18 | 33 | 20 | 6 | 17 |  |  |
| 2. Methodist | 33 | 30 | 48 | 29 | 15 | 43 |  |  |
| 3. Lutheran | 11 | 10 | 14 | 9 | 3 | 9 |  |  |
| 4. Episcopal | 5 | 4 | 8 | 5 | 2 | 6 |  |  |
| 5. United Church | 14 | 12 | 19 | 12 | 1 | 3 |  |  |
| 6. Disciples | 16 | 14 | 16 | 10 | 5 | 14 |  |  |
| 7. Baptist | 6 | 5 | 14 | 9 | 3 | 9 |  |  |
| 8. Brethren | 1 | 1 | 4 | 2 | 1 | 3 |  |  |
| 9. Miscellaneous | 3 | 3 | 11 | 7 | 0 | 0 |  |  |
| 0. NA | 1 | 1 | 0 | 0 | 0 | 0 |  |  |
| 7. Education |  |  |  |  |  |  |  |  |
| 1. 0 | 0 | 0 | 0 | 0 | 0 | 0 |  |  |
| 2. 1- 2 years | 0 | 0 | 3 | 2 | 0 | 0 |  |  |
| 3. 3- 4 years | 0 | 0 | 2 | 1 | 1 | 3 |  |  |
| 4. 5- 6 years | 2 | 2 | 5 | 3 | 4 | 10 |  |  |
| 5. 7 years | 43 | 38 | 55 | 33 | 7 | 20 |  |  |
| 6. 8- 9 years | 50 | 44 | 76 | 46 | 16 | 46 |  |  |
| 7. 10 years and over | 16 | 14 | 25 | 15 | 8 | 23 |  |  |
| 8. NA | 2 | 2 | 0 | 0 | 0 | 0 |  |  |
| 8. Pastoral Clinical Training |  |  |  |  |  |  |  |  |
| 1. 0 | 54 | 48 | 89 | 54 | 24 | 70 |  |  |
| 2. 1- 6 weeks | 24 | 21 | 24 | 15 | 2 | 6 |  |  |
| 3. 7-12 weeks | 14 | 12 | 9 | 6 | 2 | 6 |  |  |
| 4. 13-18 weeks | 10 | 9 | 10 | 6 | 0 | 0 |  |  |
| 5. 19-24 weeks | 1 | 1 | 5 | 3 | 1 | 3 |  |  |
| 6. 25-30 weeks | 0 | 0 | 3 | 2 | 0 | 0 |  |  |
| 7. 31 weeks and over | 5 | 4 | 17 | 10 | 2 | 6 |  |  |
| 8. NA | 5 | 4 | 8 | 5 | 4 | 10 |  |  |

* See TABLE A for full description of categories

TABLE E (Continued)

| | Young 20-39 yrs (113) | | Middle 40-59 yrs (166) | | Old 60 yrs- (35) | | NA (9) | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| 10. Parish Ministry | | | | | | | | |
| 1. 0- 1 year | 3 | 3 | 0 | 0 | 0 | 0 | | |
| 2. 2- 5 years | 17 | 15 | 5 | 3 | 0 | 0 | | |
| 3. 6- 9 years | 37 | 33 | 3 | 2 | 0 | 0 | | |
| 4. 10-19 years | 40 | 35 | 51 | 31 | 0 | 0 | | |
| 5. 20-29 years | 0 | 0 | 68 | 41 | 0 | 0 | | |
| 6. 30 years and over | 1 | 1 | 26 | 16 | 31 | 90 | | |
| 7. NA | 15 | 13 | 13 | 8 | 4 | 10 | | |
| 13. Threatened Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 16 | 14 | 12 | 7 | 3 | 9 | | |
| 2. 1- 2 | 13 | 12 | 16 | 10 | 5 | 14 | | |
| 3. 3- 4 | 22 | 18 | 16 | 10 | 6 | 17 | | |
| 4. 5- 7 | 14 | 12 | 23 | 14 | 3 | 9 | | |
| 5. 8-10 | 10 | 9 | 20 | 12 | 1 | 3 | | |
| 6. 11-13 | 3 | 3 | 11 | 7 | 1 | 3 | | |
| 7. 14-16 | 5 | 4 | 6 | 4 | 3 | 9 | | |
| 8. 17-19 | 1 | 1 | 3 | 2 | 0 | 0 | | |
| 9. 20 and over | 6 | 5 | 28 | 17 | 5 | 14 | | |
| 0. NA | 23 | 20 | 31 | 19 | 8 | 23 | | |
| 16. Attempted Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 37 | 33 | 30 | 18 | 8 | 23 | | |
| 2. 1- 2 | 33 | 30 | 38 | 23 | 8 | 23 | | |
| 3. 3- 4 | 19 | 17 | 31 | 18 | 3 | 9 | | |
| 4. 5- 7 | 4 | 4 | 19 | 12 | 1 | 3 | | |
| 5. 8-10 | 1 | 1 | 6 | 4 | 1 | 3 | | |
| 6. 11 and over | 1 | 1 | 9 | 6 | 1 | 3 | | |
| 7. NA | 18 | 16 | 33 | 20 | 13 | 37 | | |
| 19. Committed Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 71 | 63 | 78 | 47 | 14 | 40 | | |
| 2. 1- 2 | 23 | 20 | 42 | 25 | 11 | 31 | | |
| 3. 3- 4 | 5 | 4 | 7 | 4 | 3 | 9 | | |
| 4. 5- 7 | 0 | 9 | 8 | 5 | 0 | 0 | | |
| 5. 8-10 | 0 | 0 | 2 | 1 | 0 | 0 | | |
| 6. 11 and over | 0 | 0 | 1 | .1 | 0 | 0 | | |
| 7. NA | 14 | 12 | 28 | 17 | 8 | 23 | | |

TABLE E (Continued)

| | Young<br>20-39 yrs<br>(113) | | Middle<br>40-59 yrs<br>(166) | | Old<br>60 yrs<br>(35) | | NA<br><br>(9) | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| 22. Funerals in Total Ministry | | | | | | | | |
| 1. 0 | 44 | 39 | 33 | 20 | 3 | 9 | | |
| 2. 1- 2 | 25 | 22 | 25 | 15 | 8 | 23 | | |
| 3. 3- 4 | 11 | 10 | 13 | 8 | 3 | 9 | | |
| 4. 5- 7 | 7 | 6 | 32 | 19 | 3 | 9 | | |
| 5. 8-10 | 4 | 4 | 9 | 6 | 0 | 0 | | |
| 6. 11 and over | 3 | 3 | 16 | 10 | 5 | 14 | | |
| 7. NA | 19 | 17 | 38 | 23 | 13 | 37 | | |
| 25. Families of Suicides in Total Ministry | | | | | | | | |
| 1. 0 | 42 | 37 | 43 | 26 | 55 | 14 | | |
| 2. 1- 2 | 26 | 23 | 20 | 12 | 5 | 14 | | |
| 3. 3- 4 | 9 | 8 | 15 | 9 | 3 | 9 | | |
| 4. 5- 7 | 5 | 4 | 20 | 12 | 2 | 6 | | |
| 5. 8-10 | 2 | 2 | 4 | 2 | 0 | 0 | | |
| 6. 11 and over | 3 | 3 | 13 | 8 | 4 | 10 | | |
| 7. NA | 26 | 23 | 51 | 31 | 16 | 46 | | |
| 26. Referral | | | | | | | | |
| 1. Yes, outside church | 33 | 30 | 48 | 29 | 9 | 26 | | |
| 2. Yes, within church | 6 | 5 | 6 | 4 | 1 | 3 | | |
| 3. Both | 28 | 25 | 47 | 28 | 3 | 9 | | |
| 4. No | 18 | 16 | 31 | 19 | 10 | 30 | | |
| 5. NA | 28 | 25 | 34 | 20 | 12 | 34 | | |
| 30. Certainty in Counseling Suicides | | | | | | | | |
| 1. Certain | 12 | 11 | 32 | 19 | 5 | 14 | | |
| 2. Somewhat certain | 47 | 42 | 47 | 34 | 7 | 20 | | |
| 3. Not certain at all | 26 | 23 | 39 | 23 | 12 | 34 | | |
| 4. NA | 29 | 26 | 38 | 23 | 12 | 34 | | |
| 41. Theological Position | | | | | | | | |
| 1. 1- 5 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| 2. 6-10 | 1 | 1 | 0 | 0 | 0 | 0 | | |
| 3. 11-15 | 2 | 2 | 12 | 7 | 1 | 3 | | |
| 4. 16-20 | 33 | 30 | 51 | 31 | 13 | 37 | | |
| 5. 21-25 | 43 | 38 | 38 | 23 | 6 | 17 | | |
| 6. 26-30 | 14 | 12 | 17 | 10 | 3 | 9 | | |
| 7. Unable to determine | 20 | 18 | 48 | 29 | 12 | 34 | | |

TABLE E (Continued)

| | Young<br>20-39 yrs<br>(113) | | Middle<br>40-59 yrs<br>(166) | | Old<br>60 yrs-<br>(35) | | NA<br>(9) | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| 43. Aquinas | | | | | | | | |
| 1. Agree on all | 31 | 27 | 48 | 29 | 14 | 40 | | |
| 2. Agree on two | 21 | 19 | 22 | 13 | 2 | 6 | | |
| 3. Agree on one | 14 | 12 | 28 | 17 | 7 | 20 | | |
| 4. Agree on none | 41 | 36 | 58 | 35 | 8 | 23 | | |
| 5. NA | 6 | 5 | 10 | 6 | 5 | 14 | | |

Based on statistical trends in pastoral counseling experiences, the average minister has only moderate contact with suicidal persons in his counseling ministry. He may average one or two threatened and/or attempted suicides, funerals of suicides, and pastoral contacts with families of suicides in a given year. Persons counseled who eventually commit suicide are almost a rarity for the Protestant minister. Whether he prevents suicide in an effective manner or whether seriously-suicidal persons simply do not approach him because of the ecclesiastical moral stigma cannot be determined at this time. Undoubtedly, pastoral clinical training imparts some certainty in counseling and knowledge of referral agencies for suicidal cases.

## Case Studies

Along with the statistical study on the pastoral experience of three-hundred and twenty-three Protestant clergymen are five supplemental case studies of ministers out of the group. Actual accounts of human encounters between ministers and suicidal persons go beyond cold statistics to illustrate the unique role of the minister in suicide prevention.

## REV. ROBERT WHITE

### Introduction

Rev. Robert White, a fifty year old Caucasian, is a Presbyterian minister of a two tousand member church located near a university complex. His pastoral experiences over a twenty-five year period have included an inner city church confronted with the problem of integration; a rural town church which was badly divided when he arrived on the scene; and a college community church composed of intellectual and sophisticated persons. Out of a serious drinking problem in college and as a result of helping a suicidal girl, Rev. White saw the power of Christ in his life and in others. He surrendered to this higher life; graduated from an eastern university with a degree in sociology; and entered seminary to prepare for the ministry.

### Training in Pastoral Counseling

His seminary training in pastoral counseling was termed "woefully weak." However, he took a concentrated summer course in hospital clinical training. He still did not feel adequately trained to deal with suicidal or any other types of patients. Rev. White felt that he received his real training when he was confronted in the actual crisis situation. He also received help from an older experienced minister-friend in hospital visitation.

### First Contact with a Suicidal Person

Rev. White's first contact with a suicidal person occurred during the depression when he was twelve years old. A neighbor in his forties who lived across the street called his wife and told her about his financial losses in the stock market crash. While he was talking to her in a phone booth, he shot himself in the head. The impact of this death utterly shocked Rev. White as a little boy. He remembered the man as such a friendly, gentle person.

Accounts of Suicidal Persons in Pastoral Counseling:

Case 1.

Mr. A., a forty-two year old business man, was the husband of one of Rev. White's parishioners. Although he did not attend church, his wife and two children were quite active in the church program. Rev. White became acquainted with the family, particularly Mr. A., through home visitations. Mr. A. drove himself compulsively in his business and had a serious drinking problem when he was under pressure. Periodically the minister would hear from Mr. A.'s wife or the family doctor that the husband had made a suicide attempt and was in the hospital.

Rev. White would visit Mr. A. in the hospital and eventually a relationship was established with him. The patient sensed that the minister liked him and wanted to help him with his problems. There was also supportive encouragement from Mrs. A. Pastoral counseling was aimed at short-term supportive therapy with referral in mind. From their conversation Mr. A. revealed that he felt tremendous inferiority feelings which resulted in deep depression. His father and mother as well as his wife were powerful, resourceful, and successful persons from his standpoint. But the minister felt that Mr. A. could not break through these feelings and that the patient was living in his own personal world. Moreover, Mr. A. would not accept long-term psychiatric help. At best, therapy took the form of an effort between the minister and family doctor. After six attempts over a period of three years, Mr. A. finally committed suicide by ingesting rat poison. He had talked openly about suicide and would tell his wife about his attempts. Both the minister and family doctor felt that Mr. A. was ambivalent about death. His suicide attempts were seen as "grandstand shows" to draw sympathy and attention.

The minister sought to bring the resources of the Bible into the funeral service in order to provide strength for the remaining family. He was particularly amazed at the love of the wife for her husband. She had stood by him during these various ordeals. In his funeral sermon, the minister alluded to this love and pointed to a greater Love which would understand Mr. A.'s way of life.

Rev. White stayed close to the family during the six months following the funeral. He visited them at least twice a week in their home. The minister and Mr. A.'s wife talked about her guilt. She seemed quite relieved that it was all over and wondered whether she had the right to feel this way. The minister assured her that this was a normal reaction. He encouraged her to discuss her feelings of relief. Mrs. A. was also concerned about the impact of the suicide upon the two children. She had the sole responsibility for their support and education. The minister and the church helped to bridge this gap. Rev. White became a father figure to the two children. He took the children to different places with him and had the girl over to his house as a babysitter. He enlisted the help of several couples in the church who promised to be close to the family. The church members took the children with them on excursions so that life would not seem too meaningless. For example, the boy was interested in flying and several men in the church with airplanes would take the boy for rides.

Case 2.

Mr. B., a seventy year old retired banker, had been an active member of the church for many years. On a fall afternoon he invited a forty year old friend who also was a member of the church to join him on a hike in the mountains. After walking for a quarter of a mile, the friend suffered a fatal heart attack. Mr. B. ran for help but it was too late. The incident was an unexpected shock to the entire church. That night at a church dinner, Mr. B. was unusually quiet and acted as if nothing had happened. After a period of two or three weeks, Mr. B. became quite upset. He could not sleep and became morose. His wife was a perceptive person and could see that he was not himself. She immediately contacted the family doctor who later transferred the case to a psychiatrist. Mr. B. was treated in a hospital; received shock treatment; was under medication; and was interviewed daily by his doctor. After six weeks, Mr. B. returned home from the hospital.

Rev. White visited Mr. B. everyday for a month and a half. Mr. B. was having difficulty with his memory. He expressed doubt concerning his religious faith and wanted the minister to read meaningful scripture passages and pray with him. Rev. White felt that the patient was not grasping anything that gave him strength. The minister communicated that he was ready to talk with the patient about anything on his mind. He did not want to initiate conversation with Mr. B. about his friend's death. He felt that Mr. B. would talk about it if he wished to do so. Rev. White did point out that depression after treatment was a normal and expected reaction. He encouraged Mr. B. to take one step at a time and to be patient with himself. Mr. B. understood what the minister meant, but depression quickly came upon him again. Early one morning he climbed out of a window and jumped from the second story of his house. He did not mention suicide at all and there was no overt indication. The psychiatrist was terribly shocked by Mr. B.'s suicidal death. The minister was personally disappointed with himself. He had been a close friend of the patient and yet had not saved him. Rev. White felt that a wave of depression must have engulfed Mr. B. in a momentary loss of control.

In his funeral sermon, Rev. White shared with the family the outstanding qualities of Mr. B.: his thoughtfulness, his patience, his understanding of people. The minister wanted to tell the family that this particular act in a state of depression could not blot out this man's grandeur. They responded warmly to the message by the minister. Close contact was maintained with the family although both sons were away from home, in college and in the armed service respectively. Pastoral care took the form of correspondence with the sons. The minister also visited Mrs. B. in the home and she adjusted well to the situation.

Case 3.

Mr. C., a forty-two year old unemployed man, was overwhelmed by a series of problems. His wife was periodically in mental hospitals. He suffered from a chronic case of arthritis and often reached such a depressed state that he wondered "Why bother?". One day his wife called the minister. She was upset and wanted him to come to the house immediately. Upon arrival, Rev. White found Mr. C. in his bedroom with a loaded revolver resting on his lap. Because of his previous relationship with this man on hospital visits, Rev. White did not feel threatened in the situation. He allowed Mr. C. to express his pent-up feelings. Mr. C. had many questions: do you think that there is any sense to go on; what difference does it make if I am here or not; who cares; why should I think that my life is important to God or man; what is the meaning of my suffering? Rev. White sought to bring out God's loving concern for Mr. C. in his counseling. Regarding the question of suffering, God does not protect us from pain but He is here with us. Suffering love is found in the cross. Because God loves us, He suffers with us. Through the life of Christ one can find meaning in life.

In addition to counseling, the minister asked four church couples to bring Mr. and Mrs. C. into their circle of concern. One of the members gave Mr. C. a job which relieved some of his situational problems. The people became acquainted with Mr. and Mrs. C. The church was not only a community of faith, but became a fellowship of concern for this couple.

Case 4.

D., a seventeen year old student in a girl's private school, had been referred by the principal to Rev. White who was the chaplain of her class. She had made five suicide attempts by trying to hang herself. These seemed to be superficial attempts and D. was trying to communicate a cry for help. She was a reserved girl who was embarrassed about a counseling relationship with a minister. Rev. White structured the sessions so that D. could talk to him over the phone if a formal setting worried her. He gradually established a relationship based on confidence. Moreover, D. knew that other girls from her school came to the minister for counseling. Her suicidal crises were precipitated by an older brother who had tried to have sexual intercourse with her when she returned home on vacations from school. D. did not want to tell on her brother but at the same time, she did not know where to turn for help. D.'s father was an outstanding business executive and had little time to spend with his children because of pressing commitments across the country. Her mother had died of cancer when the children were young and her father was in his fourth marriage.

In counseling, she discussed her immediate problem. She did not feel that she could tell her parents about her brother. She even wondered whether she could talk to God about her dilemma. Could He affect the situation or was He powerless? She had an outlet with the minister, could talk through things, and eventually gained some stability from the relationship. Pastoral counseling was further enlarged after three months to include some of her questions on religion: the meaning of worship, her own spiritual life. D. began to read the Gospel of Mark in the New Testament which became a point of contact and a framework for significant questioning. The minister also gave her religious materials which pertained to her line of searching and occasionally wrote her a friendly note between sessions. D. was nurtured through the relationship and was strengthened to face her family situation.

Rev. White eventually pointed out that D. should take a sensible stand in the situation in order to have some semblance of life. He also suggested that her brother himself needed psychiatric help. D.'s father finally visited the school for a parent's function. Rev. White decided to meet him and talk to him about D.'s problems. He impressed upon D.'s father that the older brother was a sick person who needed help and that loving tenderness must be exercised in the situation. The father took the necessary action and ultimately D. faced herself and her brother.

## Suicide and Personal Theology

Rev. White saw man's self-destructive potential in the alcoholic, the bereaved, the disturbed adolescent, and the depressed. Although the final act of suicide may be dramatic, the tragedy is to witness a person in a living death. In this sense suicide is a sin because it separates one from his best self, from one another, from God. But suicide is a forgiveable sin because of the love of God.

The minister is in quest for a meaningful definition of life to share with people who have wasted their lives. Often Rev. White has felt like giving up, but has decided not to act on his feelings. He finds that he is sustained by the power of Christ and that he is responsible for his action when he feels desperate. He does something constructive in the situation. He retreats from his driving pace, draws strength from God and gains perspective on his situation.

For Rev. White, the church is the circle of concerned Christian people for suicidal persons. There is healing, hope, and redemption in close relationships so that no one should have to go through suicidal despair alone. This thrust of the church may take the form of persons available day and night for anyone with personal need.

## REV. JOHN YOUNG

### Introduction

Rev. John Young, a forty-six year old Caucasian, is the Methodist minister of a cosmopolitan down-town church of a thousand members. He has been in the church ministry for fifteen years and has served two other urban community congregations in adjoining cities. He has been deeply involved in the problems of church life: family conflicts, divorces, suicides, business difficulties, old age disillusionments, inter-faith marriages, mobility and change. He has maintained that the basic creed of Christianity is the love of God with all your heart and the love of neighbor as yourself. Rev. Young graduated from a university with a degree in business, served as a Navy officer, went to law school for a year, but finally decided that he wanted to give himself to the ministry. He then entered a graduate school of religion for further preparation.

### Training in Pastoral Counseling

Rev. Young was satisfied with the background he received in pastoral counseling at seminary. His courses included abnormal psychology, pastoral psychology, psychology of worship and prayer, and personality theory. He did clinical observation and training at several mental hospitals in the area and read widely in the field of mental illness.

### First Contact with a Suicidal Person

## Accounts of Suicidal Persons in Pastoral Counseling

### Case 1.

Rev. Young's first contact with a suicidal person turned out to be a counseling experience with Mrs. E., a twenty year old housewife who had been released from a private sanitarium after a suicide attempt. Because Mrs. E.'s mother lived next to the church, the mother and daughter attended worship service one Sunday and shortly Mrs. E. herself called Rev. Young for a counseling appointment. The minister related to her as a friend. He wanted her to feel free to talk with him about anything. Because of the understanding in the counseling relationship, Mrs. E. shared that she had recently lost a child through a miscarriage which had been a traumatic experience for her. She also argued constantly with her husband because she suspected that he was going out with another woman. She had attempted suicide by an overdose of pills the first time over marital tensions. Now the miscarriage, along with the existing domestic situation, precipitated a second attempt.

Mrs. E. married a rather domineering husband when she was eighteen years old. At first the marriage relationship meant security for her. But Mr. E. expected high ideals and proper decorum from his wife. When she failed to meet his expectations, he would criticize her. This would make her feel guilty. He was described by the minister as an efficient school teacher who was not emotionally warm toward his wife. When she lost the child by miscarriage, Mrs. E. blamed her husband for the tragedy. Moreover, she was an only child who was deserted by her father when she was twelve years old. Her mother had raised her and did not talk much about her father. When she did mention the father, Mrs. E.'s mother tried to play him up as a good person rather than refer to the severe beatings she received from him. As a child Mrs. E. blamed herself for her father's desertion. She felt that something must have been wrong with her.

At the beginning of counseling, Rev. Young contacted the psychiatrist who had treated Mrs. E. in the private sanitarium. The psychiatrist briefed him on her case history, outlined a treatment procedure for the minister, and invited further consultations if necessary. He felt that the minister could handle the after-care aspects of the case. Focusing on the suicide attempts, Rev. Young pointed out that she was not escaping from anything by suicide. He believed that one entered the next realm with the same problems. He said, "You will be there on the other side with the same difficulties that you had on this side--only compounded more. So we should solve our problems here-and-now and get rid of them because we are a part of an eternal process anyway!" Mrs. E. responded to the open confrontation. She had been depressed for a long period and the minister occasionally encouraged her with the challenges of risk and daring. He emphasized the need to work out her problems, accept herself, and get rid of her blame and guilt. The approach took the form of action therapy.

Both husband and wife came to the minister for joint and separate counseling. Rev. Young dared Mrs. E. to risk her love in relationship to her husband again. He told Mr. E. that he needed to be sensitive to his wife. The aim of the counseling was to reopen channels of communication through dating and conversation. They would report back at the next session concerning what happened. Mrs. E.'s mother also revealed her guilty feelings concerning Mrs. E.'s father. She had tried to idealize the father to her daughter. Now the mother revealed the real character of the father. Mrs. E. realized that it was her father's choice to desert the family. She was relieved by her mother's honesty. She also discovered that much of her husband's insensitivity stemmed from his insecure family background. He was not as secure as she thought. She began to develop new values about her faith and grew in her understanding of the church as a concerned community for the worth of others.

Case 2.

Mr. F., a fifty-four year old owner of a small business, was the head usher and an outstanding member of the church. He went to work on a Monday morning, walked out of his business establishment, and was missing for four days. He was later found dead in a garage in a nearby city. He had apparently committed suicide by hanging himself. Mr. F. had suffered a series of business set-backs. He was on the verge of bankruptcy and felt that he could not handle things. He had not communicated any suicidal thoughts to the minister. However, about a month prior to his death, he had almost been killed in a car accident. He also complained of terrible headaches the Sunday before the apparent suicide. He came from a poor family who lived in the South and knew the worst of the depression when there was little food or money. It was up to him to become a success and to achieve a higher standard of living. Mr. F. eventually built up a successful business with a partner who later sold out to him. But the responsibilities of business were too much for him. He was handling the bookkeeping, the sales work, the manufacturing. The business gradually collapsed on him. Rev. Young felt that Mr. F.'s previous terror of poverty in his childhood never left him and that his business failure eventually drove him to take his own life.

Both the minister and his wife immediately went to see Mrs. F. when they heard the news of Mr. F.'s death. They had known the family through the church. Rev. Young found that it was more helpful to be there as a friend than to say anything. They tried to help with errands, communicate news to others, and help her with the funeral arrangements and settlements. There were also times when Mrs. F. wanted to talk to her minister. She did have some guilt feelings about Mr. F. She felt that she should have taken better care of him when he was not feeling well. Also, she felt that she should have known that something was wrong because his head was bothering him. Rev. Young listened to her and said that this could have happened to anyone. He told her that it was not possible for her to read his mind. She was also concerned with whether God would really forgive her husband and whether he had committed the unpardonable sin. Again the minister spoke of the consistent God of love who was totally concerned for the soul of man. A redeeming God would not condemn a person. Holding each other's hands during family group prayer meant a lot to Mrs. F. Through this act of worship, she sensed the presence of God in her bereavement.

In the funeral sermon, Rev. Young emphasized the light of Mr. F.'s life: his friendliness, his interest in others, and his kindness. There was no mention of suicide. The only allusion made to suicide was when he mentioned that we do not have the answer to the question "why."

In his reflections upon Mr. F.'s suicidal death, Rev. Young felt badly that Mr. F. did not mention anything to him about it. Mr. F. was already a member when Rev. Young first came to the church. As an older man, he did not establish close communication with the young minister. Moreover, Rev. Young felt that Mr. F. would have "lost face" if he had gone to an older minister with his suicidal thoughts. Mr. F. kept all personal matters to himself.

Case 3.

Miss G., a twenty year old member of the church choir, had undergone severe family conflicts for several years. She was the only child. Her father had been a successful business executive who retired early. He was a warm person but was very rigid at times. Her mother was a very domineering person. The father often felt that he was trapped in conflicts between his wife and daughter. If he supported one, the other would become offended by it. Miss G. was not quite insistent upon her freedom. She wanted to have her own apartment and made life intolerable at home until her parents consented to her wishes. The girl, however, experienced all kinds of guilt feelings for the punishment that she inflicted upon her parents. Her attempts at liberation only multiplied her guilt feelings. She still had some "honor thy father and thy mother" feelings within her. After an argument with her parents, she needed therapeutic support.

She had done very little dating and had never had a serious love relationship in her life. During her college years she was on the verge of expulsion due to her failing grades. She felt that the better grades she received in school, the more successful people would expect her to be. During her high school and junior college years, she had received help from the school psychologists. A psychiatric social worker who was a member of the church also befriended her. She received counseling from the church's mental health clinic for a short period of time. At the time of her suicidal death Miss G. was in therapy with a psychiatrist and the minister assumed a supportive role between her sessions with the psychiatrist. However, she never stayed with any one therapist for any long period of time. It could well be that therapy became ineffective because she had spread herself out among several helping persons. Moreover, she would make, and later break, appointments with her psychiatrist.

The minister saw Miss G. the night before she committed suicide. She came to his home with a fellow. She mentioned that she had an abominable headache. The minister recognized that she was under tremendous stress, but he had seen her equally strained at other times. She had an appointment the next day with her psychiatrist, but she did not know whether she could last through the night. She wanted to know whether she could get some aspirins from the minister. Rev. Young tried to call the psychiatrist but was unable to reach him. He asked the exchange to have the psychiatrist get in touch with the girl and told her companion to follow through on it. Miss G. had given all indications that she would call her psychiatrist that night. She left the house an hour later with her friend. On the next day, she did not appear for her appointment with the psychiatrist, nor at the dinner engagement she had with her parents. She was found shot to death on a side street in her car. The suicide apparently had been premeditated although she never verbalized any thoughts of suicide. She had bought a revolver about a month prior to her death. No one had known about her purchase. Her pretext might have been due to her fear of prowlers since she was living alone in her apartment. No suicidal note was found.

Rev. Young had an opportunity to counsel with the parents after the girl's death. There was tremendous grief on the father's part and some guilt feelings expressed by the mother. However, there was a sense of relief by both parents. The minister conducted her funeral service. He used the scripture "All things work together for good to them that love God" and talked about the tragic and glorious experiences of life. Tragedies taken by themselves would sink a person, but when one builds the tragic with the triumphant life, he does not sink, but floats. Life moves toward a significant destination. Death is too heavy by itself and will sink us. But one is sustained when one builds the mystery of death with the miracle of life. There was much anguish and frustration in Miss G.'s life, but there was also the positive. She loved music, had traveled, and was successful to some extent. Her parents subsequently wrote several letters of gratitude to the minister after the funeral.

As a result of this death, a psychiatric social worker talked to the staff about suicide. A spokesman from the Los Angeles Suicide Prevention Center led a public meeting in the chapel for interested church members. Rev. Young learned that he was a finite human being in his work with another person but endeavored to sharpen his sensitivity to acute danger.

## Suicide and Personal Theology

According to Rev. Young, suicide as a threat points to our finitude as human beings and as Christians. Every human being can become depressed in stress situations. Suicide is an expression of self-anger. If a person is unable to express his hostile feelings, he turns upon himself in an act of self-destruction. As such, suicide is an abuse of freedom in the theological sense. We misuse our freedom when we move away from the true God to go our own way. In view of the suicidal threat, healing is the work of the church. God is the God of love who is concerned with the well-being of an individual. His love is consistent, no matter who we are or what we do. Jesus Christ reveals the love of God to us. The counseling relationship is a manifestation of love.

The church needs to learn about the signs and symptoms of suicide. Christianity should reform the idea that suicide is a taboo subject. Professional help is needed to deal with suicidal persons. The minister can make a preventive contribution; however, he must know his limitations and must not play god.

# REV. MARK JOHNSON

## Introduction

Rev. Mark Johnson, a forty-two year old Caucasian, is the Baptist minister of a two thousand member church located in a residential community. He has held two other parish positions: a small country church in a midwest rural community and a suburban church in a rapidly growing city on the east coast. His emphases in the work of the church have centered around Bible preaching, small groups, and retreat conferences. He pictured himself as a fundamentalist in the sense that he believes in the inspiration of the scriptures as the objective word of God, holds to the virgin birth and the substitutionary atonement of Christ, affirms the glorious return of Christ, and stresses the need of a spiritual rebirth for the individual. Rev. Johnson graduated from a university with a major in sociology and attended an eastern seminary where there was a strong emphasis on the Bible. He grew up in a "warm, evangelical home" and appreciated the Bible training received from his parents and the church. At seminary, he gained a tolerance and a respect for persons who did not believe in his particular view of the scriptures, but who were sincere and earnest in their faith. Although he often doubted his faith, Rev. Johnson returned to his fundamental beliefs which guided him in his ministry.

## Training in Pastoral Counseling

Rev. Johnson felt that he received excellent training in pastoral counseling during his seminary education. In addition to his course work, he later attended a weekly ministers' seminar sponsored by a medical center and a theological seminary for two years. His training included lectures on different aspects of religion and medicine, practice in non-directive Rogerian therapy, and evaluation of actual counseling sessions through tapes. Rev. Johnson felt inadequate and helpless in dealing with suicidal persons. He preferred referring them to a psychiatrist or psychologist who was more experienced in that field and who could probably invest more time than he could give in a crisis situation.

## First Contact with a Suicidal Person

Rev. Johnson's first contact with suicide occurred when he was ten years old. A neighbor hanged himself. Although he was too young to remember the details of the suicide, he recalled his reactions to the incident. The mere thought that a person would feel so desperate and futile left him sick. Moreover, it frightened him a great deal. The neighborhood children said that the house was haunted after the suicide and that the widow of the suicide behaved rather "spooky."

## Accounts of Suicidal Persons in Pastoral Counseling

### Case 1.

H., a sixteen year old high school boy, had an irregular counseling relationship with Rev. Johnson. They met in the minister's office about six times over a three year period. When H. was between twelve and fifteen years old, he would make an appointment when he felt like it. During this time, he was primarily concerned with his sister who had left home and was leading a beatnik way of life. His older brother had been in and out of the mental hospital. There was little communication between the parents and children at home. Although the parents were members of the church, the minister saw them as inhibited persons who were unable to relate to others or to allow others to get close to them. On numerous visits to the home, the minister observed that each member of the family seemed to live his own life and go his own way. It was as if they were afraid to ask each other what was happening. H. was bothered by the problems which he saw in his family, although the minister considered him as the healthy one in the family. He was worried about being a good brother to his sister and a good son to his parents. He also worried about being a good student in school. Rev. Johnson assumed the supportive role of a father to H. in his counseling sessions. The boy talked about each member of his family. He seemed to feel responsible for them. The minister listened and tried to help the boy understand his family: possible reasons why they were unable to communicate with each other. He told H. that God loved his brother in spite of his mental condition. He encouraged H. to love and accept his sister.

Rev. Johnson had not seen H. at church for a year before his suicidal death. H. had previously attended the high school department class on Sunday mornings, but he always sat in the back row by himself and assumed the role of a loner. Gradually, H. fell away from his faith. He was hardly missed in a church of two thousand members. The minister momentarily missed him but was absorbed with other duties. H. told his mother that he did not believe in anything. He was suffering with low grades in high school and was running around with a rough gang.

He told his parents that he was not much good to them anymore. H. had seen a psychiatrist for one visit and scheduled another but he committed suicide with a gun owned by the family at home.

The minister did not try to cover up the suicide at the funeral. Although there was no mention of suicide *per se*, Rev. Johnson said that the boy died tragically and chose this way out. God still loved him. H. believed in God and trusted in Christ. These last years of doubt had not changed his attitudes. The minister felt that he ministered in a helpful and realistic way. The parents eventually reacted in a hostile manner. They became angry at themselves, at the church, at the world, and at God. There was much self-blame. Feelings of despair and failure regarding their children poured out after many years of frustration. The church rallied around the family: attendance at the funeral, flowers, food for the family, visitation. One of the women on the church staff tried to keep communication open between the church and the family. The parents said that the church failed them, but they have been encouraged to come back to the church. Rev. Johnson has visited the parents several times since the funeral and has explored with them their hurt feelings. His ministry has been to comfort and love them. He did not feel that their behavior patterns could change too much since they were about sixty years old. Rather, his counseling aim was to stabilize the parents toward positive readjustment.

H.'s suicidal death was a learning experience for Rev. Johnson. A twelve year old child initiating counseling with a minister pointed to serious, underlying family disturbances. Rev. Johnson remarked, "I should have gotten him to a psychologist right away or I should have tried to deal with the family." He also felt that the youth staff of the church should have realized that H. was missing from the church group. But no one from the church had visited him even though he had been absent for nearly a year. Above all, the minister became more aware of non-verbal suicidal communication.

Case 2.

Mr. I., a fifty-one year old salesman and church member, was found dead in his car from carbon monoxide. He lived alone. He had taken care of his frail and invalid wife for twenty years. He portrayed the model husband in the situation. He did all the housework and was in sole charge of her care while she was living at home. She had died the previous year. Mr. I. was a respected man in the community, although he was socially aloof from others. He was critical of the minister and judged his sermons from an ultra-conservative viewpoint. He was quiet around the church and slipped in and out of the services to avoid social contacts. He was quite vocal in his criticisms of governmental policies, and violently anti-communistic when he was in social gatherings. It was difficult for the minister to relate to Mr. I. in any meaningful way.

Several months after his wife's death Mr. I. began to date a widow in the church who had lost her husband five years before. She was also inclined toward his political views and they were seen together at social events. Their engagement was accepted by both families. Mr. I. apparently committed suicide the week before the intended marriage.

Rev. Johnson learned from Mr. I's sister that he had committed suicide. (She was told by the police that it was suicide.) Mr. I.'s sister told the minister that Mr. I. felt sexually impotent because he had gone so long without sexual relationships with his invalid wife. It was his main fear in the impending marriage to the widow. The sister related that Mr. I. shared his fears with the widow, but was assured by her that they would both work on the problem. Apparently it was too much for him. At the sister's request Rev. Johnson gave no indication in the funeral sermon that he had committed suicide. The sister was ashamed about the whole stigma of suicide and few persons in the church knew that fact.

Case 3.

Miss J., a forty-five year old church education director, became acquainted with Rev. Johnson through cooperative religious projects in the city. She was subject to deep depressions and fits of crying. When Miss J. was a child, her parents were constantly in a state of conflict. Her father, a minister, died when she was sixteen years old. At times she got very angry at her mother who used her sickness as a threat. Then she would feel guilty and would ask: "What kind of a Christian am I?" Moreover, she wanted to get married, but had never experienced love with a man.

Pastoral counseling with Rev. Johnson initially dealt with her suicide threats. She talked about having pills ready or about driving over a cliff. However, she never attempted suicide. The minister pointed out that she could take her life, but that it was a miserable exit. He also reminded her of the absolute love and grace of God. But she saw God as a beast and the Christian life as a "get with it" demand. Christianity was not a life of enjoyment where one was loved and kept by God. There were suggestions made to alter her environment: a job change, transference of her mother into a rest home. From the minister's standpoint, she had the ego strength to cope with her problems. She could stand back and look at herself. She gained support through close friends. Miss J. constantly refused to consider professional psychiatric help. She felt that she ought to be able to work out her own problems. Her pride dictated to her that treatment by a psychiatrist would mean spiritual defeat for her. Her faith should be sufficient to meet her problems. Although Rev. Johnson did not feel skilled enough to deal with Miss J., he often obtained consultation from friends who were psychiatrists and psychologists.

### Suicide and Personal Theology

According to Rev. Johnson, suicide is often the way out of an extremely discouraging situation. Life becomes meaningless in the sense that there is no emotional affirmation or hope, but Christ offers hope in the distressing situation; a way out of the dilemma; and a possibility for life. One is not freed from problems, but is delivered from guilt and finds the ability to move forward in life.

The task of the church is to create prayer fellowship groups for persons with problems. Group members would minister to each other in love and concern. These groups would study the scriptures, carry persons through their problems, and would gain new dimensions in interpersonal growth.

## REV. STEVE CARTER

### Introduction

Rev. Steve Carter, a thirty-four year old Caucasian, is the United Church of Christ minister of a five hundred member church located in a low income area of a city. His congregation is composed of retired people, single young adults, and transient military personnel. In the immediate neighborhood are several broken families with divorced mothers and children. His ten year ministry has included a variety of experiences: a rural mission church, youth work in an inner city church, a circuit of small churches in the midwest, a college chaplaincy, and an associateship in a large downtown church. To him the Bible is the Word of God and Christ is God in the fullness of human flesh.

### Training in Pastoral Counseling

In his pastoral counseling courses at seminary he was taught to identify with the client and to enter into therapeutic experience with a non-judgmental attitude. Through this concept of "acceptance" there was a mutual learning experience between counselor and client which gave God an opportunity to work in the situation. Rev. Carter never had formal practical training in counseling. He taught himself through pastoral experience with troubled persons.

### First Contact with a Suicidal Person

His first recollection of suicide was with two persons who committed suicide in his church. In both instances, he failed in his attempts to refer them to other sources of professional help. The first was the case of a retired man who was severely depressed. The minister spent much time with him and tried to refer him, but the man refused more intensive help. The second was a mother with a record of mental breakdowns who was having religious fantasies. The suicide occurred the day after the minister tried unsuccessfully to get her admitted to a state mental hospital. These two experiences caused Rev. Carter to revise his strategy with suicidal persons.

### Accounts of Suicidal Persons in Pastoral Counseling

### Case 1.

K., a nineteen year old unemployed girl, had been in counseling for three years with Rev. Carter. Her condition had gradually deteriorated during the last year to a point where she was living in a world of fantasy. She told the minister some wild stories about sexual escapades with a sailor boyfriend. Rev. Carter became concerned about K. after he checked with her friends and found that these stories were fictitious. She called the minister day and night--asking his advice concerning other boys who were trying "to make her." She may have been a psychopathic liar, but the minister recognized her behavior as a cry for help. Rev. Carter related to K. as a father and gained a relationship with her. He gradually confronted her with her fantasies and pushed for a referral with a mental health clinic. After several attempts, K. entered into a fruitful relationship with a psychologist at a state mental hygienic clinic. She was seen individually by the psychologist and was later placed in group therapy. Later she got a job doing housework for a family. In return she was paid a small allowance and was permitted to live with the family. A member of the family usually supervised her and this gave her a sense of security.

K.'s family background undoubtedly contributed to her mental illness. Her real father was actually her grandfather. K.'s mother had sexual relations with her own father just before she was married. K. discovered this when she found her grandfather's name on her birth certificate. She confronted her supposed father on this and he admitted that it was true. Her grandfather had committed suicide several years before. He had shot himself when the family lived in the midwest. The marriage between K.'s mother and her husband had been unstable from the beginning. Eventually, the family (father, mother, three girls) decided to move to the west coast in order to rebuild their lives. It never happened. K.'s mother became an alcoholic. There was tension in the home life. The father and mother grew very much apart from each other. He withdrew from the house and lived nearby in a trailer. He was a machinist and a part-time painter. This was his second marriage and he had two older children by his first wife. The children from his first marriage were being taken care of by relatives.

Rev. Carter thought that a referral was a necessity when the girl continued to express suicidal thoughts. The minister knew that there had been a close attachment between K. and her grandfather. He was one of the few persons she had loved in her childhood. When he committed suicide, it was a terrible shock to K. Rev. Carter was concerned that she might follow the same pattern, especially since she had recently talked about suicide.

K. was out of the home situation due to her job. However, a crisis developed between K.'s mother and her husband. He finally exploded in anger over his wife's drinking, told her to take the car and go back to the midwest. It was an ultimatum to leave. K. called the minister for help and subsequently brought the desperate mother to Rev. Carter for counseling. He saw her every day for a week. She was agitated and depressed but slowly regained some emotional control. The minister got her to admit that she was an alcoholic and she voluntarily went to the Alcoholics Anonymous. She was doing well. She was no longer depressed, attended AA meetings every night, stopped drinking, and began to pray and read the Bible. The husband allowed her to stay at home. He began to talk about plans for a summer vacation. From every indication there was hope.

The minister and his family were scheduled to leave town for a week after Easter on a vacation. The progress of K.'s mother had been dependent upon her counseling with the minister and upon the AA fellowship. The minister felt that she could make it through the week by herself. She told him that she did not want to attend a Mother's Day party but decided to go anyway. She did not get along with her mother who was also an alcoholic. The party was scheduled while the minister would be out of town on vacation. K.'s mother agreed that she would keep in contact with her AA sponsor during the minister's basence. Moreover, they agreed to pray for each other daily at a certain time during the week. Rev. Carter felt that this would bind the commitment.

However, on the day of the party the husband forced her to go with him and the alcoholic mother (K.'s grandmother) to a bar. There they criticized her for her connections with AA and taumted her to take a drink. Furious, K.'s mother raced to the car and roared down the road. She crashed into a telephone pole, but was not injured. After being released from the hospital, she returned home and took an overdose of sleeping pills. She died on the day after the minister left town. Rev. Carter received a call from the husband on the next morning. The minister offered to come back and help in any way possible, but the husband declined any help. The associate minister of the church conducted the funeral service.

Rev. Carter was extremely disgusted at the outcome of the situation. He felt that the husband had provoked the suicide and at no time offered supportive encouragement when the wife was on the road to recovery. He was also concerned about K. Her mother often singled out the daughter as the problem. She could not accept K. whose presence was a reminder of her past mistake. The minister was afraid that K. might have a strong sense of guilt and responsibility if her mother ever committed suicide. Rev. Carter immediately contacted K. and the husband when he returned from his vacation. The church responded to the situation. They brought food to the family at the time of the funeral, cared for the home, and a widow volunteered to make some clothes for the youngest daughter. The suicide was a great relief to the husband, and he has subsequently spent much time with the grandmother. The second daughter has assumed the role of mother and is caring for the youngest girl. K. has moved back to the midwest in order to find a new life.

Case 2.

Mr. L., a thirty-three year old man, grew up in the church. He was not married and was spasmodically employed in menial work. He held a M.A. degree in physical education but had failed teachers' training due to emotional problems. Mr. L. often became depressed over job situation and personal life and would threaten to take his own life. He had been to various psychiatrists, but therapy relationships did not last very long. One psychiatrist reported that Mr. L. was a hopeless psychotic who might murder someone. Efforts were made to hospitalize the patient but no one (parents included) would take the responsibility. Everyone was afraid of him.

Rev. Carter's role was to counsel and support Mr. L. until he could be referred back into therapy. Eventually, a psychologist handled the case and the minister assumed a supportive and subordinate role. A number of persons in a prayer therapy group shared in the responsibility for Mr. L. Some would stay up all night with him and would carry him through some of his violent times. There was one week when someone was with him twenty-four hours a day because they were afraid that he might take his own life. The situation deteriorated to the point where Mr. L. was going to lose his job. Although it was only menial labor, his work was the only source of stability for him. He started showing signs of a major breakdown and his employer feared for the safety of his customers. Rev. Carter was afraid that Mr. L. might hurt someone if he was fired from his job. Therefore, the psychologist and the minister suggested that Mr. L. quit his job and spend the summer working for his favorite uncle who lived in another part of the country. It was a traumatic experience for him to leave his family. His parents had dominated and overwhelmed him so that there was a strong dependency need on his part. The decision forced him to make the break from home. At his uncle's farm in the mountains Mr. L. was therapeutically carried by a church group who took an interest in him and who brought him into a relationship with a psychiatrist. The church surrounded him with love and warmth and he lived with a minister for a period of time. The psychiatrist in the area felt that Mr. L. was on the verge of a complete breakdown and advised an immediate return to his hometown for hospitalization in a mental hospital. Mr. L. was brought to a point where he was willing to commit himself. Rev. Carter met him at the airport when he arrived back in the city.

Mr. L. was ready to commit himself but changed his mind and proceeded to another city in the northern part of the state. He got a job as a mail carrier and apparently adjusted to a semi-normal life. A minister-friend in the area was informed about the case and referred Mr. L. to a church. He has expressed positive thoughts and related that life now has meaning. Rev. Carter felt that somehow the message of acceptance was communicated to Mr. L. through various persons along the way. It took months and years of patience and love as suffering servants. But Mr. L. passed a self-destructive crisis period and has made an adjustment to life.

Case 3.

Mrs. M., a forty-eight year old chronically depressed woman, was hospitalized from an overdose of tranquilizers. She had been to a number of psychiatrists and had been exposed to shock and sleep therapy.

Mrs. M. claimed that she was turned away from a psychiatrist who said that her problems were so deep that it would take three hundred interviews and nine thousand dollars to help her. At this point, Mrs. M. approached Rev. Carter for help. Mrs. M.'s first marriage lasted twenty-five years and ended in divorce. She waited four years and then met a Mexican-American whom she married. They had been married for two years. She described her present husband as considerate but lacking affection. He seemed to live in a distant world of fantasy.

In the course of counseling Mrs. M. revealed that as a child, she had been shuttled back and forth among relatives by parents who did not want her. She had premarital intercourse with her fiance during her senior year in high school. (Her headaches began about this time.) She later broke off the engagement to date another man whom she eventually married. She admitted that she had several extra-marital affairs during the course of both marriages. Moreover, she regretted that her first marriage climaxed in divorce. She wanted to see her former husband and explain that the divorce was her fault. In short, she felt that she had made many mistakes and generally was guilty about everything. She also had deep resentments against her mother, her first husband, and especially her father. Although Mrs. M. expressed some insight about her "pain," she seemed unable to forgive the important persons in her past life. She said that she was afraid to get well. If she ever got her stability back, her present husband might make demands upon her.

Rev. Carter was able to work with a psychiatrist as a co-therapist in this case. One of the first problems was to deal with her guilt. The minister eventually impressed upon her that she could only forgive others when she believed that God loved her and forgave her sins. In order to experience love and forgiveness, Mrs. M. was placed in a prayer therapy group with eight other church women. They met one day a week, discussed a religious devotional book, and tried to relate their experiences accordingly. The group seem to give her a sense of strength and courage. Along with her relationships with the psychiatrist, occasional sessions with the minister, and her experience in the church group, she was able to make an adjustment in her life.

## Suicide and Personal Theology

In his experience with suicidal persons, Rev. Carter has noted the following characteristics: depression, inability to face reality, inability to cope with daily problems, guilt, desperation. Because suicide is a crisis situation, the minister must act quickly and know what he is doing in the situation. There have been instances when persons have called the minister and have shared their concern about possible suicidal tendencies of a friend. The minister must be sensitive to these situations and give priority to these cries for help.

In his pastoral funeral care Rev. Carter believed that one should start from the vantage point of the suicidal person. The minister pointed to Psalm 18 describing the lostness, emptiness and despair of man as well as the deliverance of death. Suicide may be the will of God. If one is sick with a physical, terminal disease, there is a time of death. If one is sick with a mental disease, he might take his own life. There are times when life may actually be futile and meaningless.

Suicide may be a necessary relief. The prospect of rest and wholeness appears to be an attractive possibility. Such relief may be in harmony with the love and will of God. Rev. Carter now realized the complex ramifications of each suicidal situation. Rather than an interpretation of suicide, Rev. Carter has focused on the comfort and love of God, the need of trust in relationships, and the avoidance of judgmentalism.

The church can prevent suicide through the fellowship of small groups. There was one instance when concerned persons stayed with a possible suicidal person for twenty-four hours. In spite of personal fear, a core of Christians were committed to give themselves in compassion to another. They were willing to risk their welfare and health. From the pastoral standpoint this is the meaning of the Church.

# REV. EDWARD GREEN

## Introduction

Rev. Edward Green, a thirty-eight year old Caucasian, is the Episcopal rector of a middle class residential church of three hundred members. He has combined community involvement with church responsibilities in two previous positions: counseling juvenile delinquents from a nearby high school, in close co-operation with police and school authorities, and counseling homosexuals, prostitutes, poor whites, skid-row alcoholics, senior citizens, as well as upper class disturbed persons, in a downtown cathedral church. Rev. Green is against theological systems *per se* when they are obstacles in the way of action between God and neighbor. He holds to an operational view of the situation rather than incrusted belief. Apart from his modernized orientation, he confesses to the supremacy and divinity of Christ, the one absolute personal Savior and the Savior of the world. From his undergraduate days as a sociology major, he found seminary to be a time of personal growth. He began to see himself in relation to other people. He could not escape life and his inadequacies in intimate situations. Pressures were placed upon him. He developed ulcers, became hostile and angry, and did "some wild, irresponsible, self-rightous things." But he had close attachments to professors and friends and they ministered to him.

## Training in Pastoral Counseling

Although every student enrolled in an Episcopal seminary in the United States is now required to take a summer of pastoral clinical training, Rev. Green had no courses in pastoral counseling during his seminary education. He learned his counseling through trial-and-error in the situations and fulfilled his needs in personal therapy from faculty and student contacts.

### First Contact with a Suicidal Person

Rev. Green's own mother was his first recollection of suicide. He was six years old when his parents had separated after a major argument. He and his mother went to live with her parents (his grandfather and grandmother). His mother wrote a note to his father, saying that she loved him and wanted him back. However, in the middle of the night, she went to the bathroom and drank a bottle of Lysol. She tried to awaken the grandfather (her father) but he had been drinking heavily and could not be aroused. Rev. Green does not remember all the details and has relied heavily on an aunt's account of what happened. He does remember being awakened by his grandfather's crying. He was ordered back to bed and was told the next morning that his mother was dead. The family tried to hide from him the fact that his mother had committed suicide, but he later discovered a note with suicidal thoughts from his mother to his father in his uncle's desk. It had been torn up and later put together with tape.

All of the family members (the grandfather, the grandmother, ~~the~~ aunt, the father) felt guilty because they reminded him that his mother would have been alive today if his grandfather had been alert and sober. In the course of personal therapy his angry feelings emerged: his mother had left him and she had no right to do so. Uncontrollable anger turned into self-pity for himself. He felt sorry for himself because he did not have a mother. No one could have been as nice as his mother. Furthermore, he blamed his father for his "raw deal." Rev. Green felt that he needed to get over his self-pity and locate the origin of his anger. His seminary professors, as well as his bishop and dean, were supportive resources. During the course of a year he was able to talk over his feelings concerning his mother's death with his father who was dying of cancer. Rev. Green felt that he worked through his feelings in the best possible way.

## Accounts of Suicidal Persons in Pastoral Counseling

### Case 1.

Rev. Green learned that Mrs. N., a thirty-eight year old woman, had been hospitalized, from her twelve year old son who was a choir boy at the church. During a hospital visit, the minister discovered that Mrs. N. had made a suicidal attempt by taking an overdose of pills. There was easy communication between the woman and the minister. A counseling relationship developed when Mrs. N. was released from the hospital. Mrs. N. had made five "half-hearted" suicidal attempts over minor disruptions: disorder with the children, unpaid bills, machinery breakdown. She would plan her suicidal attempts so that her husband or children would find her unconscious with an empty bottle when they came home at a certain time. The attempts seemed to be manipulative and controlling gestures toward her husband. This was her second marriage and his first. She had two children by her first marriage and two by her present husband. He was a successful engineer, but the family was having financial problems. He was passing bad checks.

During her counseling sessions, Mrs. N. asserted that her husband must be kept from passing bad checks and that she must cover the debts for him. She seemed compulsive and neurotic in her demands that her husband needed to curb his acting out, according to the minister. At this point, Rev. Green asked a psychologist-friend to continue therapy with the couple. At first Mrs. N. was opposed to any "head shrinker" but began to accept him after several joint-sessions with the minister and psychologist. She later made several more suicidal attempts. Rev. Green assumed a supportive role in the therapy. Mrs. N. got involved in the church drama group. She was quite an actress and there were opportunities to appear on radio and television. This seemed to give her some reason for living. She was often given the leading role in a play and enjoyed the attention given to her. Her husband was active in the church as an usher. The minister and the psychologist tried to surround the entire family with constructive activity.

However, the husband kept passing bad checks and was having affairs on the side with other women. The couple finally got a divorce. He married a sixteen year old girl and moved to another part of the state. She continued therapy for awhile, moved to another city, and went back to college. She received her B.A. and M.A. in psychology and is now working on a Ph.D. in child psychology. She is still quite anxious in general. She married again after the divorce but had the marriage annulled after two months. Her oldest son is now wanted by the juvenile authorities for bad checks. The minister feels that Mrs.

N. may still be suicidal if there is a major personal crisis.

Case 2.

Mrs. O., a forty year old housewife, came to Rev. Green in a depressed state. She said that she could no longer live with her husband. Mr. O., an intelligent engineer, ruled the house with an authoritarian voice. He seemed to have an answer for every question and problem. He kept a compulsive pattern of family living: one Sunday at their beach home and the other Sunday at church. The routine never varied on week-ends. He was regimental in household organization and would change the home furnishing "to make living more efficient." Both the husband and the wife came the second time. He said that his wife was not feeling too well. He suspected post-menstrual depression. Mrs. O. went for a physical check-up but the doctor could not find anything wrong with her. His wife admitted that she could not get out of bed in the morning, could hardly eat or sleep, felt exhausted and was unable to finish her work. She said, "Life is not worth living. Why should I be here? No one wants me. Everyone would be happier if I were not around." Rev. Green saw this as a suicidal cry for help. He immediately called the husband at his office and told him that his wife must see a psychiatrist at once. Later, Mr. O. called the minister back. He said that he was in control of himself and the situation. He promptly announced that he had made an appointment with a prominent psychiatrist.

Mrs. O. was immediately placed in the hospital and given shock treatments and medication by the psychiatrist. She returned home after a few weeks, felt much better, and was having regular sessions with the psychiatrist. Then, Mr. O. started to read magazine articles and got the idea that his wife was not emotionally ill but something else. He took her off the medication and she became worse. Both the psychiatrist and the minister recommended that Mrs. O. return to the hospital. Her husband relented and took her to the hospital. However, she did not want to stay there and pleaded with him to take her home. He took her out of the hospital against the strong advice of the psychiatrist.

A few days later Mrs. O. went to a PTA meeting in the morning with a neighbor. She arranged for children's care after school. She found a pistol hidden in the attic and went out to the backyard. A neighbor found her dead. She had taken the pistol, put it in her mouth, and blown off the top of her head. Rev. Green was immediately summoned and arrived two minutes after the husband appeared on the scene. Mr. O. wanted the minister to say some prayers and so a small service was held in the backyard. The husband cried a little, but he immediately got on the phone and made funeral arrangements in his usual efficient manner. He expressed a little guilt, but said that it was so unnecessary for her to take her own life. He could not open up to anyone. The congregation responded with food for the family and visitation to the home. The minister and the concerned church members tried to help with personal needs: babysitting, housekeeping, etc. In the memorial service, Rev. Green followed the written funeral ceremony. There were no allusions made to the act of suicide. The minister felt that she was with the Lord as much as anyone else.

Case 3.

Mrs. P., a thirty-five year old church member, came to Rev.

Green for help. Her thirteen year old son was failing in his classes and was making a poor adjustment to junior high school. Mr. P. was a chronic alcoholic who could not hold down a job. Mrs. P., however, was mainly frustrated and concerned about her son. After several sessions with the boy and in consultation with the school authority, it was arranged that he would be sent to a nearby military school. When the boy left the home situation and began to live at the academy, his grades and adjustment progressed quite well during the first year.

The family decided to spend the summer on the ranch owned by the mother's parents. Rev. Green was on his vacation in another part of the state and received a letter addressed to the church which was forwarded to him. There was a delay of a few days. It was from Mrs. P. who wrote, "Please make sure that I get back to town. I want to be buried there. I want you to take the service. I plan to take pills. I am going to do away with my life. By the time you read this letter, I will have done it." Rev. Green immediately made a long distance call to the particular town where Mrs. P. was vacationing with her family, but he was told that she had been discovered dead that morning. The minister surmised that there could have been an intervention if he had been at the church and not on vacation. He spoke to the husband and asked him about the boy and his plans. Rev. Green made an appointment to see Mr. P. when he got back to town. However, Mr. P. never returned and had a realtor sell the house.

In retrospect, the minister realized that Mrs. P. was the "sick one" while her son and husband were the "identified patients." She was actually talking about herself through her frustrations over her son. Rev. Green missed an opportunity. He should have turned the counseling focus upon her. In addition, it appeared that Mrs. P. was ambivalent concerning life and death. There would have been time for a rescue if the minister had not been on vacation. Her letter was mailed ahead of time and was intended to be ample warning for the minister.

## Suicide and Personal Theology

The thrust of the gospel and the primary goal of a Christian is to preserve life. Is a Christian guaranteed against suicide? Can a Christian commit suicide? Rev. Green pointed out that one of the last cry of Jesus Christ on the cross was, "My God, my God, why hast thou forsaken me?" It is a cry of dereliction witnessing to man's universal despair and depression. Suicide is separation from one's self and others. Rev. Green feels that the parish could be structured into groups of intimate relationships where listening and understanding can take place. There would be less of a tendency to take one's life if there existed this family network.

## Summary of Findings

These findings in no way speak for all Protestant clergymen but can only be regarded as the experience and reflection of five ministers. However, proposed conclusions based on these case studies point to the potential role of ministers in the pastoral counseling of suicidal persons.

1) The Parish Minister. All five men were ministers of churches ranging from three hundred to a thousand members in residential, inner city, and educational settings. The clergymen were between the ages of thirty-four and fifty and had been in at least two other parish situations before this one. The emphases of their ministry varied from interest in social action through family problems to the preaching of the Bible. From the brief statements on their theological positions, all affirmed the love of God and the supremacy of Jesus Christ in the life of the church in varying ways. Each was a college and seminary graduate with a minimum total of seven years of higher education. In short, these parish ministers seemed to be typical of the average Protestant clergyman in the local church of the United States.

2) Training in Pastoral Counseling. Personal opinion varied as to the quality of the pastoral counseling training received in theological seminary. Mr. White termed his training as "woefully weak" whereas Mr. Johnson felt that he received excellent training at his school. Most of the ministers received some formal training in course work as well as hospital clinical training. One or two of the men said that they had no formal education in pastoral counseling but learned

through trial-and-error experiences and through continuous consultations with psychiatrists and psychologists in the course of their parish ministries. Almost none of the five clergymen had received any substantial training in suicide prevention. They learned through experience in close co-operation with a medical professional. Findings from these five ministers indicate that seminaries as well as suicide prevention centers (e.g. the Los Angeles Suicide Prevention Center) should provide training programs to educate clergymen in the counseling of suicidal persons.

3) Initial Contact with a Suicidal Person. Several ministers indicated initial contact with a suicidal person in their childhood. It usually involved a neighbor or an acquaintance of the family. Since many initial contacts with suicide occurred in the early period of development, ministers should investigate the possibility of blocked feelings toward suicide in personal therapy to insure an adequate counseling ministry to suicidal persons.

4) Unique Contributions of Pastoral Counseling to Suicide Prevention. The case studies revealed that these ministers had significant experiences with suicidal persons in the work of the parish. Rev. Robert White and Rev. Edward Green encountered suicide in their home and hospital visits in the parish. Post-hospital care took the form of intensive marriage counseling between Mr. and Mrs. E. However, Mr. B.'s recurring depression and failure of memory as well as advanced age should have suggested to Rev. White and the psychiatrist that further hospitalization was required for his own protection. Therefore, clergy-

men should be alert to the possible signs of suicide in their visits to homes and hospitals. There may be "open-door" opportunities for further preventive counseling.

*Biblical therapy and personal growth groups in the church* were also forms of pastoral therapy for suicidal persons. Later pastoral counseling for D. took the form of reading the gospel of Mark in the New Testament which not only gave her some spiritual directions but may also have fed her "emotional hunger." In the case of some ministers, active intervention prevented suicide. The establishment of a relationship between D. and Rev. White might have prevented a possible suicidal death after five minor attempts on her part. Furthermore, Rev. Green took immediate steps to contact Mrs. O.'s husband and to arrange for immediate therapy and hospitalization by a psychiatrist.

Ministers played an important role in *post-hospital* after-care of suicidal patients. Concerning personal growth groups, Rev. Carter related that during the course of a week a group member was with Mr. L., a potential suicide, twenty-four hours a day. Mrs. M. was also helped by a group experience in prayer therapy to find some evidence of love and forgiveness. Group experiences in both cases were supplemented by therapy from psychiatrists and periodic supportive-counseling from the minister. A variation on the personal growth group approach was the use of the church drama group for active therapy in the case of Mrs. N. Rev. Green described how this activity gave Mrs. N. some reason for living during a period of time.

*Funeral and post-funeral pastoral care is* the proper function of the minister and his church. Funeral sermons ranged from no mention of suicide to indirect allusions to the suicidal act. Positive qualities of the person were related when there was any form of eulogy. The minister and the church functioned in a strategic manner to family survivors of suicidal deaths. In the case of Mr. A., Rev. White filled the role of a father-substitute to the children and further involved other couples in the church with the family. Clergymen can also counsel family survivors who have unresolved feelings, particularly questions regarding the after-life and the moral stigma attached to the suicidal act. The restoration of broken lives due to a suicide is an important task of the pastor and the church.

5) Areas of further improvement for pastoral case to suicidal persons. Unexpected suicides underscore the need for clergymen to recognize suicidal signs. Mr. A.'s suicidal death after six attempts over a period of three years suggests that the minister and family doctor should have urged the wife to assume the responsibility for immediate commitment to a mental hospital. Arrangements for re-admission into a hospital should have been made for Mr. B. He showed signs of a high suicide risk: advanced age, recurring depressions, and failure of memory. Often suicidal signs must be de-coded from cryptic language known only to a suicide himself. Clergymen should acquire training to spot the characteristics of a suicide. Of course a minister cannot predict the fate of every suicidal person. At best, he can use his past experiences as future lessons for improved pastoral care.

## III. PSYCHOLOGICAL CONTRIBUTIONS

The preceding statistical and case studies indicate that adequate suicide prevention for clergymen should consider the following areas: characteristics of suicidal personality, therapy for suicidal persons, assessment of lethality intention, and understanding of death. Research findings by the Los Angeles Suicide Prevention Center will serve as practical psychological models for clergymen.

1) Characteristics of the Suicidal Person. Several unexpected suicides were related by clergymen in the case studies. Retrospective studies of cases of committed suicide by the Los Angeles Suicide Prevention Center indicate that the suicidal victim previously revealed his self-destructive intention in a preliminary way: verbal threat, conversation about suicide, recent suicide attempt, specific behavioral changes. In his description of suicide as a gradual process, Robert E. Litman, chief psychiatrist of the Los Angeles Suicide Prevention Center, explains:

> The person under stress feels restless, uneasy, painfully tense and unable to adapt. At first, suicide is only one of many reactions. He tries solution a, solution b, solution c, solution d and feels no improvement. He thinks of solutions e, f, g, h and i, and improvement. Finally, he comes to solution s - suicide. He struggles against it, abandons it, tries other thoughts, other actions. Sometimes nothing helps. He loses hope and returns repeatedly to thoughts of suicide. As his thinking grows more distorted, constricted, confused and desperate, he signals his preoccupation with self-destruction by words, actions and symptoms.[8]

One of the most practical contributions for clergymen from the research of the Los Angeles Suicide Prevention Center is the delineation of specific signs of the suicidal person. Litman outlines the following factors: age and sex, onset of self-destructive behavior, method of possible self-injury, recent loss of loved person, medical symptoms, resources, status of communication with patient, kinds of feelings expressed, reactions of referring person, personality status and diagnostic impression.[9]

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[8] Robert Litman, "Acutely Suicidal Patients Management in General Medical Practice," California Medicine, CIV, 3 (March, 1966), p. 169.

Concerning age and sex, generally the older the person, the more serious is the self-destructive potentiality. The largest number of total deaths by suicide occur between the ages of forty and sixty-five. Suicidal communication from males should arouse more concern than similar communication from females, since the ratio of suicidal death of males to females is four to one. Ministers should be aware of older persons in a suicidal crisis. Regarding the onset of self-destructive behavior, the more acute the onset, the better the ultimate prognosis but the greater the need for active intervention. If there has been a pattern of suicidal behavior over an extended period of time, the eventual prognosis may be extremely ominous. Such chronic cases demand long-term rehabilitation. Crisis circumstances involving a loss or a failure may precipitate a gradual or sudden deterioration of personality and result in suicidal behavior. The method of possible self injury sometimes is a reliable indication of the degree of emergency. In general, a specific choice of time, place, and method for the proposed suicide is a serious indication as opposed to a vague generalized suicidal threat without any definite suicidal plan. Lethal methods include: firearms and explosives, hanging, carbon monoxide auto fumes, barbiturates, poisoning, and drowning. Lethal means should be kept from depressed persons or suspected suicides.

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[9] Robert Litman, "Emergency Response to Potential Suicide," Journal of the Michigan State Medical Society, LXII (January, 1963), pp. 69-71.

Many suicide attempts occur after the recent loss of a loved person. Exaggerated mourning and grief reaction may be accompanied by strong self-destructive urges. Ministers in their post-funeral pastoral care should observe the effect of the death upon acquaintances. A resultant suicide attempt could be interpreted as a fantasy desire for reunion with the deceased, as a guilt atonement, as a tired wish for exit, as an angry wish to kill or to punish or as a hopeful wish to be rescued, reborn or forgiven. A history of recent hospitalization or medical consultation may indicate increased self-destructiveness, especially in older persons. Ministers in their hospital visitations should be aware of medical symptoms most associated with suicidal reactions: psychosomatic diseases, cancer, poly-surgery, and various indications of depression such as anorexia, weight loss, sleeplessness, fatigue, loss of sexual desire and hyprochondriacal preoccupation. Seventy-five percent of suicides have seen a physician within six months of the death. If self-destructive tendencies are suspected in a patient who has such medical symptoms, both minister and physician should work together in the therapeutic prevention of suicide. Resources of the persons should be assessed along with other factors. Does the suicidal person have a "significant other" (spouse, relative, or friend) as a resource? As Norman Tabachnick and Robert E. Litman have stressed:

> The suicidal person is strongly dependent on others for his emotional security. He can accept criticism by them as long as it is not accompanied by complete rejection. If he should completely lose significant individuals or valuable objects he probably will try to replace them with others; however, under certain circumstances this manuever is unsuccessful and at such a time suicide will result.[10]

Often economic factors such as a recent loss of job or a sudden drop in financial status represent a significant loss of resource, especially for middle-aged men and career women. Thus, a person may have exhausted himself interpersonally and financially and may be emotionally bankrupt. The church and its minister can represent the significant other resource person for suicides and can restore depleted resources.

A suicidal person who is able to express his troubled feelings is a less potential danger than one who has given up, has withdrawn, and is no longer communicating with others. The importance of _communication with the suicidal patient_ is illustrated in the telephone conversation between suicidal callers and staff-members of the Los Angeles Suicide Prevention Center. Litman describes the process:

> Various techniques are used to widen the patient's view of the world, re-establish his sense of self-identity, and encourage communication between him and the persons who could play a significant role in his life. History-taking is used not only to gain information about the potential strength and resources of the patient but also to remind him of his past, present, and future - that is, to remind him of his identity.[11]

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[10] Norman Tabacknick, and others, "Comparative Psychiatric Study of Accidental and Suicidal Death," _Archives of General Psychiatry_ (January, 1966), p. 67.

[11] Robert E. Litman, "Police Aspects of Suicide," _Police_ (January-February, 1966), p. 5.

The minister should assess the communication aspects of the suicidal person. Such questions have no harmful effect according to the Los Angeles Suicide Prevention Center. Rather, a person is relieved to discuss his problems with a concerned person. The _state_ of the suicidal person should also be assessed. The most serious suicidal potential is associated with feelings of helplessness, hopelessness, exhaustion, and failure. There is somewhat less lethal danger when feelings of frustration, anger, or rage without overwhelming confusion predominate. Most important, ministers should assess the degree of depression in the suicidal person. Depression is characterized in the following way:

> The syndrome of depression includes physical symptoms such as loss of appetite, insomnia, loss of sexual capacity and interest, weight loss, anorexia, abdominal distress, headache and other things. At the same time that he presents these physical symptoms, the patient may complain of feelings of sadness, worthlessness, despair, and unhappiness. In addition, there will be supporting evidence of a dropping off in previous areas of interest, a loss of enthusiasm for work and his hobbies, a withdrawal from social contacts, and others. The primary feature of the depressive syndrome will be the element of change. In most instances, the patient will seem like a completely different person from his usual self.[12]

Feelings of ambivalence between life and death also predominate in the suicidal person. The suicide wants to kill himself but he also desires to be rescued and to resume his life. The positive desire for life in ambivalence can be used as a therapeutic force in suicide prevention by the minister.

The _reactions of the referring person_ is also important for the therapy of the suicidal person. It is encouraging when the referring person expresses sympathy and concern with an admission of helplessness and need for assistance. Little help can come from a referring person who is also disturbed and clearly needs a sick dependent partner to lean on him. Norman Tabachnick describes this dependent and masochistic relationship in the following way:

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[12] Norman L. Farberow, Edwin S. Shneidman, Robert E. Litman, "The Suicidal Patient and the Physician," _Mind_ I:69 (March, 1963), p. 3.

> It should be pointed out that the significant other individual is also dependent and masochistic. He needs the suicidal attemptor because he needs someone to whom he can give but he has chosen an object who makes him suffer.
>
> In fact, what one sees in such a situation is a symbiotic relationship between two individuals who are dependent and masochistic; who are angry at each other but who don't know what they are essentially angry about (which are the conflictual feelings arising out of their dependence on each other); and who are quite likely to express their anger in some importantly rejecting way. A suicide attempt may often be the result of such a rejection.[13]

The minister should evaluate the condition of the referring person in terms of a possible sick dependency relationship. Moreover, personal therapy should be a requirement for all clergymen who work with suicidal persons. Such a relationship as described by Tabachnick could occur if the minister is unaware of his dependency needs. The Los Angeles Suicide Prevention Center recommends multiple-counseling whereby the suicidal person is the responsibility of several therapists. In this way, no single counselor is over-invested in a possible symbiotic relationship. However, some emotional reaction is expected from a professional person who is dealing with a suicide. Emotions activated by suicide go deep into the human psyche beyond the usual concept of counter-transference.

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[13] Norman Tabachnick, "Interpersonal Relations in Suicidal Attempts: Some Psycholdynamic Considerations and Implications for Treatment," (an unpublished mimeographed paper), pp. 4, 5.

Finally, personality status and diagnostic impression of the suicidal person should be assessed. Is there enough evidence of psychiotic behavior and severe depression to warrant hospitalization? Or can the suicidal person be an out-patient on an active weekly therapy program? Has there been previous hospitalization for mental illness, previous psychotherapy, previous suicide attempts (number and frequency), extent of the depression? Any high ratings in these areas suggest a high suicidal risk. Immediate hospitalization is required under the care of a psychiatrist. The Los Angeles Suicide Prevention Center has devised a rating - scale, "Assessment of Suicidal Potentiality," as well as a "SPC Contact Work Sheet." A minister should familiarize himself with these two instruments and should evaluate the suicide in terms of the findings based on the information that can be gathered. (See Appendix for "Suicide Prevention Center Assessment of Suicidal Potentiality" and SPC Contact Work Sheet").

2) Personality Theory of Suicide. Ministers who work with suicidal person should familiarize themselves with personality theory of suicide. At the Los Angeles Suicide Prevention Center considerable research has further expanded the implications of Sigmund Freud's view on suicide. In brief, Freud's view of suicide as hostility directed toward the introjected loved object (or what Edwin S. Shneidman has called "murder in the 180th degree").[14] Robert E. Litman in a paper,

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[14] Edwin S. Shneidman, "Orientations Toward Death," in Robert W. White, ed., The Study of Lives (New York: Atherton Press, 1963),

"Sigmund Freud on Suicide" has listed the general and specific features of suicide according to Freud. He said:

> There are, according to Freud, *general features* of the human condition, at least in Western civilization, which make each individual person somewhat vulnerable to suicide. These general features include:
>
> (a) The death instinct with its clinical derivatives, the aggressive instinct directed outward and the destructive instinct directed inward.
>
> (b) The splitting of the ego. This is inevitable because of the extreme helplessness of the human ego in infancy when it is unable to master its own instincts and must conform to the parents or perish.
>
> (c) The group institutions, family and civilization, which require guilty compliance from every member of the group.
>
> Individual suicides involve certain *specific suicide mechanisms*. All of them involve a breaking down of ego defenses and the release of increased destructive, instinctual energy. Examples are: (a) loss of love objects, especially those who have been loved in certain dangerous ways; (b) narcissistic injury through fatigue or toxins; (c) overwhelming affect: rage, guilt, anxiety, or combinations; (d) extreme splitting of the ego with decathexis of most elements and a setting of one part against the rest; and (e) a special suicidal attitude and plan, often based on an identification with someone who was suicidal.[15]

While there has been an emphasis on aggression and guilt in suicide studies[16], research at the Los Angeles Suicide Prevention Center has tended to underscore other personality aspects in suicidal persons. Based on two-hundred and eighteen suicide cases of neuro-psychiatric hospital patients, Norman L. Farberow, Edwin S. Shneidman, and Charles

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pp. 204, 205.

[15] Robert E. Litman, "Sigmund Freud on Suicide," (an unpublished mimeographed paper), pp. 24, 25, 28.

Norman L. Farberow, Edwin S. Shneidman, Charles Neuringer, "Case History and Hospitalization Factors in Suicides of Neuro-psychiatric Hospital Patients," *The Journal of Nervous and Mental Disease* CXLII:1 (1966), p. 42.

Neuringer characterized the suicide as a "dependent-dissatisfied" person. Based on these findings they concluded:

> The "dependent-dissatisfied" person was that person who was continually complaining, demanding, insisting and controlling. He showed inflexibility and lack of adaptability, continually repeating his demands on others regardless of their effect on them. He turned to hospital and staff for support but continually succeeded in alienating them with his insatiable demands for special attention. He seemed to need constantly repeated evidence of self-worth from outside sources in order to maintain his own feelings of self-esteem. However, his own activity continually pushed him into a more difficult "bind," for as he increased his demands, his sources of gratification were exhausted and became more rejecting, forcing the patient to increase his demands still more.[17]

Further elaborations of this type of personality have uncovered the suicide as a dependent and infantile person. He expects others to make decisions and do work for him. Such behavior is related to oral deprivation in early infantile development with the mother. The suicide attempt is thus a symbolic re-experiencing of an earlier rejection by a mother figure. Linked to the dependency aspect is often a striking degree of masochism. In its severe form Litman estimates that ten percent of suicides could be termed "malignant masochism." Such persons (often beautiful women who stir up intense rescuing needs in therapists and leave them feeling bereaved) seem to be in love with death and often have a history of a dead or absent parent as the most significant love object. Usually they have been severely abused in childhood by someone whom they felt demanded death as the price of love. Generally, they are able to enter into regressive symbiotic relationships with persons meaningful in their lives. Efforts to work through such involvement on a therapeutic level tend to produce states of deep depression, alternating with acting out behavior in the form of repeated suicide threats and attempts.

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[17] Norman Tabachnick, "Countertransference Crisis in Suicidal Attempts," (an unpublished mimeographed paper), p. 1.

With a knowledge of such personality theory a minister could work as a co-therapist with a psychiatrist. At best, a minister must know the limitations in his own personality make-up, clinical training background, and commitments to other aspects of his parish ministry.

3) Therapy for Suicidal Persons. Therapy for suicidal persons consists of many levels of help. Psychological support is transmitted by a firm and hopeful attitude. Although the patient seems to be overwhelmed in a suicidal crisis, the minister familiar with suicide should communicate that such a condition is common-place and that many similar persons have made complete recoveries. The minister should point out that the person is in a temporary suicidal crisis which can be shortened with proper help. Hope is also conveyed through structured interpretation and understanding regarding the problem and the assessment of the suicidal potentiality. Such optimism based on direct evaluation and contact fulfills the need of the suicidal person for a sympathethic reaction.

The self-destructive person is often paralyzed into immobility and is constricted in his perception of the solutions. Suicidal action may be a negative attempt to regain some ability to act. The Los Angeles Prevention Center has found that action therapy in the form of a series of planned and organized activities re-establishes ego-identity.

The suicidal person is aware that help is on the way. Staff members often set up a series of telephone calls where resource persons (family, minister, doctor, social and psychological agencies, etc.) rally around the suicide. Psychological testing is employed to assess personality and to involve the person in another form of action. Central to action therapy is the clinical interview. Litman states the purpose of the interview:

> During the interview we remind the person, by our questions, who he is and what he is. He reviews his identity as a husband, job-holder, father, citizen, etc. At the same time, questions about his present problem and situation are aimed at widening his view of the world and reminding him of alternative possibilities to explore, and of possible additional solutions to what appears to him to be a dead end.[18]

The therapist assumes a directive role as a good authoritative figure who takes charge of the suicidal person until there is a recovery of judgment and reason. Consultations between staff members alleviate the tensions of suicidal counseling and encourage imaginative solutions to particular problems. The minister in his traditional role as an authority can construct a plan of action therapy for the suicide in conjunction with psychiatric consultation.

When the suicidal potential is considered high, immediate hospitalization means a safe place of control for the suicidal person and also underscores the emergency nature of the crisis. This is especially imperative if there is poor response from the significant other and also formulation of a definite suicide plan. If the suicidal patient will not voluntarily enter the hospital, a family member should recommend legal court committment based on the fact that "the person is a danger to himself and/or to others." The three months after leaving the hospital is a crucial period for suicide. Of the hospital patients who eventually commit suicide, about half commit suicide within three months after discharge. A minister in his hospital visitation can prepare a suicidal person for post-hospital rehabilitation. Reassimilation of the suicide into family and community life can be the task of the church and its minister.

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[18] Litman, "Emergency Responses...," p. 72.

4) Assessment of Lethal Intentionality. There have been previous attempts to classify suicidal behavior. The classical sociological typology of suicide was given by Emile Durkheim in the eighteenth century: altruistic, egoistic, and anomic. By altruistic suicide, Durkheim meant disciplined attachment to a group such that the obligations of the social group override the individual's interests and result in suicide. By egoistic suicide, Durkheim meant instances where the individual is forced to turn to his own conscience and assume responsibility for his own acts concerning suicide. By anomic suicide, Durkheim meant suicide which involves the individual who has been suddenly thrown out of kilter with the important relationships to the social group. However, apart from a sociological approach, the traditional pattern has been to use a Natural-Accidental-Suicidal-Homicidal death classification and to categorize suicide in terms of threatened, attempted, and committed.

Recently, Edwin S. Shneidman has called attention to the assessment of suicidal behavior according to the lethality of his acts and the intention toward death. Shneidman has called this concept "lethal intention." His discussion on lethal intention in suicide is related to death, specifically a consideration of the terms: _cessation_, _termination_, _interruption_, and _continuation_. By _cessation_, it is meant the stopping of the potentiality of any further conscious experience. Based on the individual's own attitude and orientation toward death, only man has the mental ability to conceptualize his cessation. By _termination_, it is meant the stopping of the physiological functions of the body which may not coincide with cessations. By _interruption_, it is meant the stopping of consciousness with the actuality and usually the expectation of further conscious experiences. It may be a kind of temporary cessation. By _continuation_, it is meant the experiencing (in the absence of interruption) the stream of temporally contiguous conscious events.[19]

Lethal intentionality is related to the role of the individual in his own cessation. _By the role of the individual relevant to his cessation_, Shneidman means the following areas of personality understanding:

> ... his attitudes and beliefs about death, cessation, hereafter, and rebirth; his ways of thinking; his need systems, including his needs for achievement, affiliation, autonomy, and dominance; his dependencies and hostilities in relation to the significant people in his life; the hopefulness and hopelessness in the responses of these people to his cries for help; the constellation and balance of ego activity and ego possivity; his orientations toward continuation states.[20]

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[19] Shneidman, "Orientations Toward Death," pp. 204-211.

[20] _Ibid_., p. 212.

These various factors determine the degree of lethal and non-lethal intentionality in the death of an individual. In specific terms, Shneidman evaluates cessation (lethal and non-lethal) in terms of intentioned cessation, subintentioned cessation, unintentioned cessation, and contraintentioned non-cessation. By intentioned cessation, it pertains to cases where the individual plays a direct and conscious role in the precipitation of his own demise. By subintentioned cessation, reference is made to cases where the individual plays an indirect, covert, partial or unconscious role in his own demise. Cessation of this type may often be accompanied by psychological processes, such as the individual's seeming carelessness, foolhardiness, forgetfulness, change of mind, lack of judgment. By unintentioned cessation, it describes cases where the person psychologically has no conscious intention toward hastening cessation and plays no significant role in his own demise. In general, most natural, accidental and homicidal deaths are under this category. By contraintentioned non-cessation, there is no cessation and no traditional modes of death involved. Contraintentioned cases refrain from suicide.

Since a minister is concerned about the suicide phenomena in terms of pastoral counseling and theological ethics, he must determine lethal intention especially in suicidal cases involving subintentioned cessation. The degree of lethal intention helps to evaluate the suicidal act. Shneidman answers the argument that one may have insufficient background to make such estimations in suicidal cases. He argues:

> It might be protested, inasmuch as the assessments if these intentioned states and Psyde categories involve the appraisal of unconscious factors, that some workers (especially lay coroners)

> cannot legitimately be expected to make the kinds of psychological judgments required for this type of classification. To this, one answer would be that coroners throughout the country are making judgments of precisely this nature everyday of the week. In the situation of evaluating a possible suicide, the coroner often acts (sometimes without realizing it) as psychiatrist and psychologist and as both judge and jury in a quasijudicial way. This is because certification of death as suicide does, willy-nilly, imply some judgments or reconstruction of the victim's motivation or intention.[21]

Although reference is made to the coroner's investigations of suicides, the minister needs background in the evaluation of lethal intention.

The minister can improve his pastoral counseling to suicidal persons through a mastery of the psychological principles laid down by the Los Angeles Suicide Prevention Center. Basic to suicide prevention is the immediate recognition of suicidal signs by the minister and trained laymen in the church. Actual counseling with suicidal persons should be a joint therapeutic venture between the minister and psychiatrist. Such a gradual introduction to the personality and therapy of suicidal persons will give the clergyman the time to familiarize himself with the dynamics involved as well as to test out the suggested therapeutic principles advocated by the Los Angeles Suicide Prevention Center.

## IV. CRITIQUE

The typical parish clergyman has contact with suicidal persons, although not in substantial numbers. Pastoral clinical training programs in suicide prevention should be established and improved in theological schools as well as in hospital programs for clergy. Personal therapy of ministers should be encouraged in order that feelings regarding suicide may be worked through. The fifteen brief case studies indicate that pastors made unique contributions in suicide prevention: home and hospital visitation, active intervention, post-hospital after-care, Biblical therapy, personal growth groups in the church, and funeral and post-funeral pastoral care to the surviving family.

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[21] _Ibid_., p. 221.

Contemporary changes in theological ethics as well as in pastoral counseling convince us that the Old Model is no longer relevant to suicide prevention. A formulation of a Revised Model based on these contemporary changes must be based on an integrative factor between theological ethics and pastoral counseling.

# CHAPTER V

# THE REVISED MODEL

In every generation there have been revisions of theological systems within the framework of the Christian church. In light of traditional formulations and contemporary changes, we suggest that there should be an attempt to combine theological ethics and pastoral counseling into a revised model on the problem of suicide for consideration by the modern church. Moreover, the parish clergyman confronts ethical and therapeutic problems in his ministry to suicidal persons. He can make a unique contribution to the suicide prevention movement through a practical integration of both areas.

## I. INTEGRATION FACTOR

In the fields of religion and psychotherapy, there has been much discussion concerning the concept of responsibility.[1] Furthermore, the basic approach of the Los Angeles Suicide Prevention Center includes therapeutic responsibility. As Norman Tabachnick states:

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[1] H. Richard Niebuhr, The Responsible Self (New York: Harper and Row, 1963).

O. Hobart Mowrer, The New Group Therapy (New York: D. Van Nostrand, 1964), pp. 1-13.

William Glasser, Reality Therapy (New York: Harper and Row, 1965).

Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (New York: Abingdon, 1966), pp. 18, 19, 27-36.

> As our treatment methods evolved through the years, we found the treatment with these people included the following techniques: a supervisory and ego-synthesizing direction by the therapist; encouragement, both overt and by implication, that the person was capable of dealing with problems in his life that had heretofore been considered unsolvable and on which, therefore, no effort had been expended; indications to the patient that the therapist did not feel completely responsible for the patient's life and future. This approach seemed to be valuable, not only in helping patients over crises, but also in helping them move in the direction of more responsible behavior.[2]

Based on these indications our intention is to describe the suicidal person as well as the minister in terms of 'responsibility'. Furthermore, our aim is to employ the concept of responsibility in our own way and to infuse the familiar term with new meaning.

## II. AREAS OF INTEGRATION

A basic framework is required to correlate theological ethics and pastoral counseling. Aside from methodological considerations, the areas of integration are defined by specific categories, devised by leading authorities in their respective fields.

From the perspective of Protestant theological ethics, James M. Gustafson has listed the crucial components: 1) social or situational analysis; 2) fundamental theological affirmations; 3) moral principles; and 4) the nature of the life in Christ and its proper expressions in moral conduct.[3] Concerning pastoral counseling, William A.

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[2] Norman Tabachnick, "Failure and Masochism," American Journal of Psychotherapy, XVIII, 2 (April, 1964), p. 305.

[3] James M. Gustafson, "Context Versus Principles A Misplaced Debate in Christian Ethics," Harvard Theological Reviews, LVIII:2 (April, 1965), pp. 197, 198.

Clebsch and Charles R. Jaekle have analyzed the healing, sustaining, guiding, and reconciling aspects of pastoral care.[4] It is our feeling that the categories themselves suggest the following correlations between theological ethics and pastoral counseling: 1) situational analysis--sustaining; 2) theological affirmations--healing; 3) moral principles--guiding; and 4) the nature of the life in Christ and its proper expressions in moral conduct--reconciling.

1) Situational Analysis--Sustaining. The predicament of the suicidal person is internal conflict in which his being is ruled by destructive power. On the one hand, he may be an overly dependent person who is hungry for emotional warmth and acceptance. On the other hand, he may be hostile and use his hostility to conceal his dependency needs, but his hostile attacks against others only incur more rejection and isolation and produce guilt feelings. Frantic attempts toward a solution exhaust the suicidal person. His will to cope with life gradually deteriorates to the extent that the suicide is no longer willing to put forth the effort to respond to life. Concerning the hopelessness over life, Paul Tillich observes:

> Suicide (whether external, psychological, or metaphysical) is a successful attempt to escape the situation of despair on the temporal level. But it is not successful in the dimension of the eternal. The problem of salvation transcends the temporal level, and the experience of despair itself points to this truth.[5]

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[4] William A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective (Englewood Cliffs, N.J.: Prentice-Hall, 1964), pp. 32-66; see also Seward Hiltner, Preface to Pastoral Theology (New York: Abingdon, 1958) for a discussion of the terms healing, sustaining, and guiding.

[5] Paul Tillich, Systematic Theology (London: James Nisbet, 1964),

Thus, the suicidal person can never escape the reality of his alienated existence through the act of suicide from the Christian perspective.

Not only is individual responsibility impaired but the typical suicidal death has grave social repercussions. Edwin S. Shneidman describes the social implications of suicidal death:

> His unnecessary and untimely death, in terms of dollars and cents only, often involves something of the following items: municipal or county ambulance; coroner's time and facilities; widow's and survivor's benefits and insurance; some heightened possibility of subsequent indigent relief for the widow and children; a definitely heightened probability of the need for subsequent mental health care in a mental hospital or clinic for the surviving children--not to mention the loss to local and national community of around a quarter-century of taxes. We can estimate that the actual average cost of one such suicide ranges from somewhere like a hard figure of $50,000 to as much as over a million dollars per person. And those cold numbers do not touch upon the trail of guilt and misery typically created in the survivors by each suicidal death.[6]

As a result of the suicide, each member of the surviving family affix blame on something or someone and as members of society the entire family is scarred with the bitter tragedy of a suicidal death.

However, inspite of the self-destructive aspects of suicide, the pastoral counselor should recognize the positive expression of self-affirmation in the suicidal act. As the pastoral counselor is sensitive to the human condition, he may detect that the suicide is desperately groping to regain his life. If the minister is able to channel this motivation drive, he may sustain the life of the suicidal person. The immediate responsibility of the pastoral counselor is to

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III, 88.

[6] Edwin S. Shneidman, "A Comprehensive NIMH Suicide Prevention Program" (an unpublished mimeographed paper), p. 29.

establish a relationship within which a suicidal person may choose life rather than death. As Paul Pretzel declares:

> The main purpose in dealing with a person in a suicidal crisis is to keep him alive, and to take whatever action is necessary to protect the person from himself. Once the crisis has passed, however, and the immediate danger of suicide has somewhat lessened, once the flood of feelings have abated to the point where they are more manageable, the role of the clergyman can change from that of crisis intervention to that of helping the person reestablish his own life.[7]

In other words, the task of the clergyman is to help the suicidal person fulfill his potential and creative self.

To sustain the life of a person is to offer a genuine supportive relationship during a suicidal crisis. After active intervention, the sustaining ministry focuses on a program of active therapy in order to rebuild responsible action. As a constructive authority figure, the minister can exemplify a responsible person and help the suicide respond again to a satisfying life. Through his acceptance, support, and directive manner the clergyman can stabilize the emotional resources of the suicide. After the initial crisis period, the pastor can provide the groundwork for an eventual referral to a medical professional or supplementary supportive counseling in co-operation with a psychiatrist, psychologist, or mental health agency.

2) Theological Affirmations--Healing. The source and goodness of life are the primary theological affirmations of ethical responsibility regarding suicide. Implicit for the pastoral counselor is the

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[7] Paul W. Pretzel, "The Clergy and Suicide Prevention" (an unpublished mimeographed paper), p. 29.

recognition that God has given life to man. The responsibility of man is to preserve his life and to acknowledge the prerogative of God over life and death. The divine intention is that man may respond with ethical responsibility in the confession of his creaturehood, his social involvement, and the sovereignty of God.

From a theological perspective the suicide rather affirms his freedom, disregards the social implications of his action, and usurps the sovereignty of God. He communicates basic unbelief and mistrust in the one true God. Perhaps this is the point of contact where the effective pastoral counselor is able to minister to the suicide. Paul W. Pretzel points out the lack of religious trust in self-destructive persons:

> Organized religion has not been able to offer any significant help to these suicidal persons. The very presence of the Church appears to be a threat to them, and they see the Church--and the God about which the Church preaches--as being judgmental and excluding. The theological doctrines of Grace, Forgiveness, Love have made no impact upon our subjects and instead serve to intensify their feelings of isolation, unworthiness, and helplessness.[8]

Written and verbal theological appeals to responsibility may have little effect on him. As H. Richard Niebuhr describes human self-destruction:

> In our wretchedness--we see ourselves surrounded by animosity. We live and move and have our being in a realm that is not nothingness but that is ruled by destructive power, which brings us and all we love to nothing. The maker is the slayer; the affirmer is the denier; the creator is the destroyer; the lifegiver is the deathdealer.[9]

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[8] Paul W. Pretzel, "Suicide and Religion: A Preliminary Study" (an unpublished Th.D. thesis, Southern California School of Theology, Claremont, Calif., June, 1966), p. 249.

[9] Niebuhr, Op. cit., p. 140.

> We do respond to One action in all the many actions upon us, but that One in all the many is the _will_ to destroy, or, if _will_ be too anthromorphic a term, the _law_ of our destruction.[10]

Implicit in a theology concerning suicide is the gospel of healing. It is not a case of therapy preceded by religion but the integration of spiritual resources in the form of a caring relationship. A pastoral theology on suicide is neither a doctrine of condemnation nor a verbal rejection of the suicidal condition but the love and acceptance of the pastoral counselor. The restoration of trust is the healing task of the minister. Often the suicidal person is emotionally indifferent to a direct theological affirmation. Regardless of this, the pastoral counselor is to incarnate the message of healing. As the representative of God and his church he communicates basic trust through Christian love. The suicidal person may eventually understand that GOD CARES FOR HIM and a gradual development of basic trust in the universe and God. Thus, the promise of life may replace the threat of death. However, the pastoral counselor should respect the religious belief or unbelief of the suicidal person. Basic trust tends to transcend religious propositions. Its healing power is positive feelings and ultimate values.

3) _Moral Principles--Guiding_. As a general rule, theology asserts that most suicides are self-destructive acts which violate the moral principles of the good and the responsible. However, some may question whether religion has the right to prevent suicide. A person

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[10] _Ibid_.

may covet the freedom to govern the time and mode of his death. The suicide may not seek any form of therapeutic help. Furthermore, a rational person may be impelled by his philosophy of life to commit suicide as an expression of his life style. In these cases, the pastoral counselor must respect the personal integrity of the individual. That part of the Judaic-Christian tradition which affirms life has indirectly influenced social and cultural norms against suicide. However, the pastoral counselor must realize that he does not determine the fate and freedom of the individual. The clergyman can not play god and rule over life and death. At best, he can provide the suicidal person with the therapeutic conditions which will be conducive to life and can maintain open channels for communication and help.

Related to these issues is the philosophical orientation on the subject of suicide by various therapists. Robert E. Litman reports:

> My colleagues and I have never interviewed a therapist who advanced the notion that the suicide of his patient was philosophically acceptable to him and congruent with his theoretical expectations regarding the methods and goals of therapy. The concept of an autonomous and insightful individual initiating an act of self-validation or self-fulfillment was not mentioned in these post-mortem discussions.[11]

Thus, neither the principles of ethics nor the philosophy of therapy generally affirm that suicide is a moral or therapeutic act.

The guiding aspect of pastoral counseling is concerned with the morality of suicide. Therapeutic guidance recognizes that ambivalence--the internal dialogue of the soul which struggles between life and death--governs the suicidal person. The pastoral counselor directs the patient to reaffirm life. Action therapy guides the suicide to consider better ways to fulfill his needs. After the initial crisis, the pastoral counselor helps the suicidal person to reflect on the meaning of good action. Certainly a suicidal death which violates prior responsibility (e.g. to wife and children) is a clear case of irresponsibility. Man is responsible for the maintenance of his life when the welfare of other persons is dependent on him. Such an investigation of the meaning of life may be the basis for a continuing relationship between the suicidal person and the pastoral counselor. The question of the worthiness of living may be an open door to the needs of the suicidal person in the course of the guidance ministry of the pastor.

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[11] Robert E. Litman, "When Patients Commit Suicide," American Journal of Psychotherapy, XIX, 4 (October, 1965), p. 574.

4) The Nature of the Life in Christ and its proper expression in Moral Conduct--Reconciling. Reconciliation is the pervasive goal of pastoral counseling with the suicidal person. To be reconciled is to be restored to the community as a responsible member. In the reconciling process the suicidal person is gradually related to himself, to others, and hopefully to God. His immediate resources may be family, friends, doctor, minister, and other members of his community. These significant others may be suicide-prevention resources as well as avenues of communication for the suicidal person if they are healthy assets and can contribute to the positive life of the suicide. Furthermore, there may even be growth toward harmony with ultimate reality.

Crucial to reconciliation is an understanding of the meaning of the Christian life and its application to forms of moral conduct. The primary message of the Christian gospel for the suicidal person is neither a condemnation of the suicidal act nor an adherence to stringent ethical demands. Rather, it is the embodiment of love (or Christ) in the person of the pastoral counselor. Though the modern clergyman must recognize the lethality of the suicide potential, meet the suicide crisis with adequate forms of therapy, and grapple with the ethical implications of suicide, these tasks are not easy to accomplish. On the one hand, an involvement with techniques for suicide prevention may exclude any consideration of the ethical revision required of the church on theoretical and practical levels. On the other hand, an obsession with elaborate ethical schemata may neglect an awareness that the clergyman must also develop the therapeutic skills in order to save a life. A distortion of therapeutic or ethical responsibilities fails to account for the primary object in the issue of suicide: the welfare of the suicidal person. Only as the pastoral counselor has the interest of the suicide in the forefront of his concern can there be any advancement in the church's contribution toward the problem of suicide. The meaning of the Christian life and its performance in moral conduct warrant an understanding of the suicidal person.

The task of our study has been a brief attempt to furnish the church with a renewing contribution on the subject of suicide. In part, contemporary trends in theological ethics themselves demand a change from a strict condemnation of the suicidal act to a discrete understanding of the suicidal person from an ethical perspective. In short, there is a need for a reformulation of the ethical flavor of the church on suicide even though there may be ecclesiastical agreement on suicide prevention. However, the appearance of the modern minister as a pastoral counselor also compels a revision of the church's understanding of its ministry to suicidal persons.

Our effort is offered as a suggested correlation of ethical and therapeutic responsibility for an operational model by the parish minister. We have stated that with proper suicide prevention training the clergyman is able to be an effective therapist. The minister may explore with the suicidal person such appropriate areas as the meaning of personal existence, the restoration of a satisfying life, the shaping of values, and the question of ultimate reality. Arising from these discussions are ethical and therapeutic dimensions. Our contention has been that the concept of responsibility can meaningfully speak to these two aspects of the suicide issue. However, we acknowledge that further attempts should be made to pursue other modern restatements of the church's stance on the problem of suicide.

## III. AREAS FOR FURTHER RESEARCH

Areas for further research based on the findings of our study are:

1) Pastoral contact with persons who eventually commit suicide. A previous national survey indicated that forty-two percent of all emotionally troubled persons first contacted a clergyman. Our findings suggested that half of the three-hundred and twenty-three ministers in our questionnaire study had no counseling contact with a person who

eventually committed suicide in their total parish ministry. Differences should be explored between the two studies in terms of sampling, degree of emotional disturbance, effectiveness in counseling, and other factors which may point to possible explanations in this discrepancy. Further studies could determine whether ministers effectively prevent suicide and are able to save lives through counseling and/or by referral or whether suicidal persons deliberately avoid the use of ministers and seek help through other resource agencies.

2) Pastoral Clinical Training. Our study indicated that no substantial trends could be determined to correlate pastoral clinical training with certainty in counseling experience. Moreover, fifty-four percent of the three hundred and twenty-three ministers in the questionnaire said that they had received no formal pastoral clinical training. Research should establish the type and quality of clergy training regarding suicide prevention available in hospital and/or agency training programs. Furthermore, follow-up studies on the effectiveness of pastoral counseling to suicidal persons should be undertaken.

3) The deterrent issue. Fifty-eight percent of the Protestant ministers said on the questionnaire that ecclesiastical pronouncement against suicide is not an effective preventive factor. Comparison should be made from the orientation of the Roman Catholic church which operates from a tradition of ecclesiastical pronouncement upon members within their structure. The denial of burial rites against rational suicide might also be a significant preventive influence over suicidal

persons who are of the Catholic faith. The use of ecclesiastical pronouncement against suicide in pastoral counseling might reveal a therapeutic effect in case study material.

4) Along with this attempt to revise the issue of suicide in terms of the responsibility concept in theological ethics and pastoral counseling, other possible integration factors should also be constructed with the same intention in mind. Various expressions in theology as well as psychology (e.g. anxiety, despair) can be modes of further dialogue in these two areas.

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# APPENDIX

SUICIDE PREVENTION CENTER
2521 WEST PICO BOULEVARD
LOS ANGELES, CALIFORNIA 90006
TELEPHONE: DUNKIRK 1-5111

PROJECT CO-DIRECTOR:
NORMAN L. FARBEROW, PH.D.
PROJECT CO-DIRECTOR AND CHIEF PSYCHIATRIST:
ROBERT E. LITMAN, M.D.
ASSOCIATE CHIEF PSYCHIATRIST:
NORMAN TABACHNICK, M.D.
PSYCHIATRISTS:
ALBERT SCHRUT, M.D.
SAUL H. BORASH, M.D.
CHIEF PSYCHOLOGIST:
CARL I. WOLD, PH.D.
PSYCHOLOGIST:
MICHAEL L. PECK, PH.D.
CO-CHIEF SOCIAL WORKERS:
SAM M. HEILIG, M.S.W.
DAVID J. KLUGMAN, M.S.W.
STAFF SOCIAL WORKERS:
ROSITA ALFARO, M.S.W.
JOHN RANDELL, M.S.W.
PSYCHOLOGICAL AND PASTORAL COUNSELOR:
PAUL W. PRETZEL, TH.D.
SENIOR CONSULTANT:
LOUIS I. DUBLIN, PH.D.
SOCIOLOGIST CONSULTANT:
MAMORU IGA, PH.D.
NURSING CONSULTANT:
KAREN KLOES, R.N., M.S.
ASSOCIATE IN PSYCHOLOGY:
ALCON G. DEVRIES, PH.D.
VISITING CLINICAL FELLOW (1966-1967):
KENSHIRO OHARA, M.D.

Dear Pastor:

The research staff of the Los Angeles Suicide Prevention Center and the pastoral counseling department of the School of Theology at Claremont are interested in your pastoral care experiences and theological views on the problem of suicide.

I am therefore conducting a preliminary investigation of personal, theological, and pastoral care views on suicide. The survey includes the Protestant churches affiliated with the councils of churches in Los Angeles County.

I am asking your help by requesting that you complete this questionnaire. All replies will be kept strictly confidential. Check or circle the most appropriate answer provided.

If you have any question about this form, please phone me on Fridays 9:30-4:30, at DU 1-5111. If you are further interested in problems of counseling with suicidal persons, staff members of the Los Angeles Suicide Prevention Center, 2521 West Pico Boulevard, Los Angeles, DU 1-5111, will be glad to talk with you.

Thank you. Please return the form in the envelope as soon as possible.

Sincerely,

Doman Lum
Pastoral Counselor, Clinical
Associate with the Los Angeles
Suicide Prevention Center

DH:hs

SUICIDE PREVENTION CENTER
2521 WEST PICO BOULEVARD
LOS ANGELES, CALIFORNIA 90006
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ASSOCIATE IN PSYCHOLOGY:
ALCON G. DEVRIES, PH.D.

VISITING CLINICAL FELLOW (1966-1967):
KENSHIRO OHARA, M.D.

Dear Pastor:

You may have received this questionnaire several weeks ago but have not been able to complete it. We do not have a record of a returned questionnaire from you. If you mailed in the information on your pastoral care experience of suicide, please disregard this request.

The research staff of the Los Angeles Suicide Prevention Center and the pastoral counseling department of the School of Theology at Claremont are interested in your pastoral care experiences and theological views on the problem of suicide.

The survey includes the Protestant churches affiliated with the councils of churches in Los Angeles County. All replies will be kept strictly confidential. Check or circle the most appropriate answer provided.

If you have any questions about this form, please phone me on Fridays 9:30-4:30, at DU 1-5111.

Thank you. Please return this form in the envelope as soon as possible.

Sincerely,

Doman Lum
Pastoral Counselor, Clinical
Associate with the Los Angeles
Suicide Prevention Center

DL:hs

## QUESTIONNAIRE FOR CLERGY INFORMATION ON SUICIDE COUNSELING AND THEOLOGY

Instructions: I am asking your help by filling out this questionnaire. All replies will be kept strictly confidential. Please answer all questions, when relevant to your situation. Fill in or circle the most appropriate answer provided. If you have never counseled a suicidal person, check here _____ and answer questions 1-7; then skip to the section, Personal Interpretation of the Theological Positions on Suicide.

1. Name and Address ____________________________ 2. Age ____________

3. Name of your church 4. Denomination

_______________________________________________________________

5. Education: college or university (years) _____; seminary (years) _____; post seminary ______

6. How many weeks of pastoral clinical training in a hospital or correctional institution? (circle one) none 1-6 7-12 13-18 19-24 25-30 31 or more

7. How many years have you served in: (fill in)
   a. your parish ministry in Los Angeles County _____
   b. your total parish ministry _____

8. How many persons have you counseled who expressed suicidal thoughts in: (fill in)
   a. your parish ministry in Los Angeles County during the year of 1965 _____
   b. your parish ministry in Los Angeles County _____
   c. your total parish ministry _____

9. How many persons have you counseled who attempted suicide in: (fill in)
   a. your parish ministry in Los Angeles County during the year of 1965 _____
   b. your parish ministry in Los Angeles County _____
   c. your total parish ministry _____

10. How many persons counseled who eventually committed suicide in: (fill in)
   a. your parish ministry in Los Angeles County during the year of 1965 _____
   b. your parish ministry in Los Angeles County _____
   c. your total parish ministry _____

11. How many funerals for suicide have you had in: (fill in)
    a. your parish ministry in Los Angeles County during the year of 1965 _____
    b. your parish ministry in Los Angeles County _____
    c. your total parish ministry _____

12. How many families of persons counseled who committed suicide in: (fill in)
    a. your parish ministry in Los Angeles County during the year of 1965 _____
    b. your parish ministry in Los Angeles County _____
    c. your total parish ministry _____

13. Taking your last few cases, did you frequently refer suicidal persons to an agency or professional person outside or within the church: (check one)
    a. _____ Yes, outside the church; b. _____ Yes, within the church;
    c. _____ Both; d. _____ No

14. Were you aware of the existence of the Los Angeles Suicide Prevention Center before receiving this questionnaire?
    Yes _____; No _____

    If yes, have you ever referred counselees to LASPC? Yes _____; No _____

15. In suicidal cases (check one); a. _____ I feel certain I can do a helpful job, with or without outside referral; b. _____ I feel somewhat certain; c. _____ I feel not certain at all. (Please write on back of this sheet any further comments on this matter.)

Personal Interpretation of the Theological Positions on Suicide
(Circle one)

16. Suicide is a sin because by killing himself, he injures the community of which he is a part. Agree Uncertain Disagree

17. Suicide is a sin because it assumes the prerogative of God who alone has the right to give life and take it away. Agree Uncertain Disagree

18. Suicide is a sin because every man should love himself and therefore suicide is contrary to natural law and to love. Agree Uncertain Disagree

19. Suicide is not a sin because the Bible nowhere explicitly states this. Agree Uncertain Disagree

20. I believe that a strong ecclesiastical pronouncement against suicide deters parishioners from taking their lives. Agree Uncertain Disagree

21. I would give the full burial rites of my church to a rational person who has committed suicide. Agree Uncertain Disagree

22. I would give the full burial rites of my church to a mentally unbalanced person who has committed suicide. (Some religious bodies will not give the full burial rites unless the suicidal dead person is seriously disturbed enough to be called mentally ill.) Agree Uncertain Disagree

23. Suicide is a forgivable sin because God judges the content of the last hour in the context of the whole. Even a righteous man may be momentarily in the wrong by the act of suicide at the last. Agree Uncertain Disagree

24. There are situations in which God may actually give man the freedom and permission to destroy himself, so that he cannot be regarded as a suicide in the bad sense. Agree Uncertain Disagree

25. I believe that religion encourages suicide because it historically speaks glowingly of an afterlife and has often been pessimistic about this world. Agree Uncertain Disagree

26. If you feel that these statements do not adequately convey your personal theological views on suicide, please feel free to set down your views on the back of this sheet.

Thank you. Please return the form in the envelope enclosed to:

Doman Lum
Los Angeles Suicide Prevention Center
2521 West Pico Boulevard
Los Angeles, California 90006

# STATISTICAL CODING FORM

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 |
| 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 |
| 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 |
| 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 |
| 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 |

# of SPC contacts ____ SPC CONTACT WORK SHEET Time ____ (am) (pm)
Duration of call ___

Night call ____ Day call ____ Day ____ Date ______________

Patient ____________________ Staff member ______________

Address __________________________ Tel No. ______________

City ________________________ County ______________

Who called (Name & relationship) ____________________

Address & City ____________________ Tel No. ____________

How know about SPC ______________ Prior SPC Contact __________
With whom ______________

Why referred: SA; ST; SB; SI; None For info ____ Consult ____
Action ____

Age ___ Birth Date __________ Sex: M F Marital: S M W D S MM

Race ___ Religion _______ Occupation __________ Annual Income _______

Education completed ________ Sex, # & ages of children _________

______________________________________________

Suicide Potential (1-9) ___

Statement of problem:

Chronic ___ Acute ___ Prev. Sui. Behavior ____________________

Previous medical and/or psychiatric trtmt:

Current medical and/or psychiatric trtmt:

Disposition: (Include calls to relatives, friends, police, physician, recommendations to patient or caller, etc.):

Suicidal Potentiality Criteria: 1) Age and sex; 2) Prior suicidal behavior; 3) Method-threatened or attempted; 4) Loss of loved one; 5) Communication aspect; 6) Medical symptoms; 7) Resources; 8) Mood, feelings, behavior; 9) Diagnostic impression, referral, self or other; 10) Feelings of informant.
CONTINUE COMMENTS ON REVERSE SIDE, INCLUDING INFORMATION ON FOLLOW_ UPS, PLEASE.

Name ______________________ Age ______ Sex ______ Date __________

Rater ____________________ Evaluation _________ 1 2 3456 78 (9)
L M H

## SUICIDE PREVENTION CENTER
## ASSESSMENT OF SUICIDAL POTENTIALITY

This schedule rates suicide potentiality. By "suicidal potentiality" is meant generally the possibility that the person might destroy himself. In general, the rating is for the present or the immediate future.

Listed below are categories with descriptive items which have been found to be useful in evaluating suicidal potentiality. The list is not meant to be inclusive, but rather suggestive. Some items imply high suicidal potentiality, while others imply low suicidal potentiality. Some items may be either high or low, depending on other factors in the individual case.

The numbers in parentheses after each item suggest the most common range of values or weights to be assigned that item. Nine is highest, or more seriously suicidal, while one is lowest, or least seriously suicidal. The rating assigned will depend on the individual case. The rater will note that some categories range only from one to seven.

For each category the rater should select the item(s) which apply and place the weight he would assign it in the parentheses at the right of the item. (More than one item may apply.) The rater should then indicate his evaluation of his subject in that category by placing a number from one to nine (or one to seven) in the column headed, Rating for Category. In those categories where the descriptive item is not present for the subject being rated, write the item in and assign a weight in the parentheses following.

The overall suicidal potentiality rating may be found by entering the weights assigned for each category in the box, front page, totaling, and dividing by the number of categories rated. This number, rounded to the nearest whole number, should also be circled at the top of the front page.

---

SUICIDE POTENTIAL:

A&S ______
Sy ______
St ______
AvC ______

SIP ______
Res ______
PSB ______
MedSta ______
Comm ______
RoSo ______

TOTAL ______

No. of categories rated ______

Average ______

1. AGE AND SEX (1-9) Rating for Category ( )

Male
50 plus (7-9) older person, higher suicide ( )
35-49 (4-6) ( )
15-34 (1-3) ( )

Female
50 plus (5-7) ( )
35-49 (3-5) ( )
15-34 (1-3) ( )

2. SYMPTOMS (1-9) Rating for Category ( )

Severe depression: sleep disorder, anorexia, weight loss, withdrawal, despondent, loss of interest, apathy. (7-9) ( )
Feelings of hopelessness, helplessness, exhaustion. (7-9) ( )
Delusions, hallucination, loss of contact, disorientation. (6-8) ( )
Compulsive gambler. ( )
Disorganization, confusion, chaos. (5-7) ( )
Alcoholism, drug addiction, homosexuality. (4-7) ( )
Agitation, tension, anxiety. (4-6) ( )
Guilt, shame, embarrassment. (4-6) ( )
Feelings of rage, anger, hostility, revenge. (4-6) ( )
Poor impulse control, poor judgment. (4-6) ( )
Frustrated dependency. (4-6) ( )
Other (describe): ( )

3. STRESS (1-9) Rating for Category ( )

Loss of loved person by separation. (5-9) ( )
Loss of job, money, prestige, status. (4-8) ( )
Sickness, serious illness, surgery, accident, loss of limb. (3-7) ( )
Threat of prosecution, criminal involvement, exposure. (4-6) ( )
Change(s) in life, environment, setting. (4-6) ( )
Success, promotion, increased responsibilities. (2-5) ( )
No significant stress. (1-3) ( )
Other (describe): ( )

4. ACUTE VERSUS CHRONIC (1-9) Rating for Category ( )

Sharp, noticeable, and sudden onset of specific symptoms. (1-9) ( )
Recurrent outbreak of similar symptoms. (4-9) ( )

Recent increase in long-standing traits. (4-7) ( )
No specific recent change. (1-4) ( )
Other (describe) ( )

5. SUICIDAL PLAN (1-9) Rating for Category ( )

Lethality of proposed method -- gun, jump, hanging, drowning, knife, poison, pills, aspirin. (1-9) (more lethal for men -- gun, hanging) ( )
Availability of means in proposed method. (1-9) (women -- barbituates) ( )
Specific detail and clarity in organization of plan. (1-9) ( )
Specificity in time planned. (1-9) ( )
Bizarre plans. (4-6) ( )
Rating of previous suicide attempt(s). (1-9) ( )
No plans. (1-3) ( )
Other (describe): ( )

6. LACK OF RESOURCES (1-9) Rating for Category ( )

No sources of support (family, friends, agencies, employment). (7-9) ( )
Family and friends available, unwilling to help. (4-7) ( )
Financial problem. (4-7) ( )
Available professional help, agency or therapist. (2-4) ( )
Family and/or friends willing to help. (1-3) ( )
Stable life history. (1-3) ( )
Physician or clergy available. (1-3) ( )
Employed. (1-3) ( )
Finances no problem. (1-3) ( )
Other (describe): ( )
rally people around - get people in the act - closest possible person

7. PRIOR SUICIDAL BEHAVIOR (1-7) Rating for Category ( )

One or more prior attempts of high lethality. (6-7) ( )
how he did it - rescue, put on act - ambivalent about dying - life forces
One or more prior attempts of low lethality. (4-5) ( )
History or repeated threats and depression. (3-5) ( )
No prior suicidal or depressed history. (1-3) ( )
Other (describe) ( )

8. MEDICAL STATUS (1-7) Rating for Category ( )

Chronic debilitating illness. (5-7) ( )
Pattern of failure in previous therapy. ( )

| | |
|---|---|
| 9. COMMUNICATION ASPECTS (1-7) | Rating for Category ( ) |
| Communication broken with rejection of efforts to reestablish by both patient and others. (5-7) | ( ) |
| Communications have internalized goal, e.g., declaration of guilt, feelings of worthlessness, blame, shame. (4-7) | ( ) |
| Communications have interpersonalized goal, e.g., to cause guilt in others, to force behavior, etc. (2-4) | ( ) |
| Communications directed toward world and people in general. (3-5) | ( ) |
| Communications directed toward one or more specific persons. (1-3) | ( ) |
| Other (describe): | ( ) |

| | |
|---|---|
| 10. REACTION OF SIGNIFICANT OTHER (1-7) | Rating for Category |
| (way of next kin reacts is significant) unconscious past of script-malignant sign | ( ) |
| Defensive, paranoid, rejected, punishing attitude. (5-7) | ( ) |
| Denial of own or patient's need for help. (5-7) | ( ) |
| No feelings of concern about the patient; does not understand the patient. (4-6) | ( ) |
| Indecisiveness, feelings of helplessness. (3-5) | ( ) |
| Alternation between feelings of anger and rejection and feelings of responsibility and desire to help. (2-4) | ( ) |
| Sympathy and concern plus admission of need for help. (1-3) | ( ) |
| Other (describe): | ( ) |

* * * * * * * * * * * *

UNION THEOLOGICAL SEMINARY

Broadway at 120th Street

New York, N. Y. 10027

April 28, 1966

Mr. Doman Lum
1401 North College Avenue
Claremont, California

Dear Mr. Lum:

Let me reply to your letter of 12 April and say first of all that I regret having put you to the trouble of a second communication.

You will realize I am sure that the matter you have raised with me in your letter is one which involves more than a casual reply. During the weeks since your first inquiry came, I have been more than usually involved in commitments and teaching. With the best of will, therefore, I have been unable to send you the information for which you have asked.

Even now I must content myself with the briefest comment. Actually my own approach to the problem of suicide is best understood with reference to what is now being discussed in theological ethics, both Roman Catholic and Protestant, under the rubric of "the ethics of the exception." Perhaps the best statements of this general position are available in Karl Barth's Church Dogmatics, Volume III/4 and in the work of Helmut Thielecke called "Theological Ethics." Barth's work is available in translation though Thielecke's is not as far as I know. There is a brief discussion in the Ethics of Dietrich Bonhoeffer and some passing attention to the problem as I recall in an earlier book by Joseph Fletcher called Morals and Medicine.

To come to your other two questions let me just say that as regards the role of psychiatry in the ethics of suicide, there are of course other options to an approach from the perspective of Eric Fromm. The question seems to me to be whether and in how far the best insights of psychological research and clinical findings can be appropriated in the course of a theological analysis which is concerned with two questions, mainly, namely the limits of power over life and death and the relation between human weakness and despair and the grace of God.

These last two points concern me very much as I try to think through the question of suicide as a crucial "ethical exception." This means at least that suicide cannot be condemned out of hand and cannot be read as a ground for excluding a person who takes his own life from the fellowship of the church and the means of grace. In this respect the tradition of Christian ethics is in my judgment seriously in default. At the same time, suicide is in my view a deep symptom of the alienation of man from God and a sign of the fact that we all continually stand in need of divine mercy and grace.

I hope these all to brief comments may be of some little help in connection with your work.

Yours sincerely,

(signed) Paul L. Lehmann

PLL:jc

PRINCETON UNIVERSITY
Princeton, New Jersey

Christian Ethics
R. Paul Ramsey

Department of Religion
613 Seventy-nine Hall

May 10, 1966

Dear Mr. Lum,

My response to your letter will not be of much help to you. You seem to know the places to go in the literature--past and present theologians. To this I have not much to add, except the two books by Norman St. John-Stevas. I myself regard Barth's special ethics very highly; and am at present working on something on The Sanctity of Life in the First and the Last of It - but the Last refers to euthanasia and medical ethics, not suicide. I have not dealt with that except in a footnote *contra* the justification of self-immolation in an unpublished paper.

In general, it seems to me to be of the utmost importance to distinguish between *ethical* justification and *ethical* excusability. Because this distinction is *not* made, we Protestants - out of compassion to excuse and understand individual cases - have wrongly made *this* depend on situational ethical *justification*. Since, however, a chief function of *ethical* judgments is to condemn and reform social systems and the conditions of men, not to condemn *agents* and *acts* only or mainly. I, for example, would see *in*sufficient warrant for the "institution" for which you now work if its *basis* was only the identification and help of only those who *really* don't *want* to commit suicide (it being judged that what's right in this regard is *made* by the integrated will alone; and to violate the will is only way to violate a man, or for a man to violate his life).

Sincerely yours,

(signed) Paul Ramsey

# BIOGRAPHICAL DATA

Doman Lum was born on September 23, 1938 in Hamilton, Ohio. He is the son of Mr. and Mrs. Edward K.W. Lum, 2450 Coyne Street, Honolulu, Hawaii. His education was in the public schools of Hamilton, Ohio and Honolulu, Hawaii. He graduated from the University of Hawaii with a Bachelor of Arts in English in 1960 and from Fuller Theological Seminary with a Bachelor of Divinity in 1963. In June 1967 he received the Doctor of Theology degree in pastoral counseling and psychology from the School of Theology at Claremont, California. His dissertation title was "Suicide: Theological Ethics and Pastoral Counseling".

His professional associations include the Academy of Religion and Mental Health and the American Association of Pastoral Counselors. He is a member of the First Chinese Church of Christ in Honolulu, Hawaii. On June 25, 1967 he married the former Joyce Wong of Tucson, Arizona. They reside in Honolulu, Hawaii where Mr. Lum is a minister in the Hawaii conference of the United Church of Christ.